

National Institute of Mental Health

HANDBOOK OF MENTAL HEALTH CONSULTATION

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and
Mental Health Administration



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**HANDBOOK
OF
MENTAL HEALTH CONSULTATION**

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To the memory of JAMES W. OSBERG, JR.,
M.D. (1920-1986), an extraordinary practitioner, teacher, and administrator and one of the pioneers of family and community psychiatry.

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FOREWORD

Current practices in mental health care financing stress reimbursement for transitional interventions through direct service approaches. Mental health consultation has thus undergone a period of decline. Nevertheless, mental health consultation, once seen as an essential service of community mental health centers, has developed a large body of knowledge and will, no doubt, play an expanding role in community mental health activities in the future.

There are a number of reasons why mental health consultation, where mental health information is shared with those working with others in order to improve, expand, and strengthen the mental health service capacity, will remain significant. Some of these follow:

1. Mental health consultation cuts across levels of prevention. It may be directed toward chronic conditions, mild to severe acute disorders, or reducing symptomatology stemming from stressful living and working conditions (all of which are, to varying degrees, clinical in nature), as well as enhancing social-psychological conditions in the general population which are necessary for optimal development and well-being. It has recently been found useful with self-help-oriented approaches.
2. As a helping method, mental health consultation can intervene at the psychological, social, cultural, economic, and physical levels. For example, mental health consultants to an inpatient facility can consult around psychological factors in treatment, social factors in discharge planning, physical factors in the design of building (arrangement of furniture, use of colors and art work, etc.), economic factors in strengthening the capacity for public relations, continuing education, and cultural factors through increasing the sensitivity of staff to understanding cultural diversity in designing intervention programs.
3. Mental health consultation, both as a concept and practice mode, cuts across disciplines, i.e., it is not within the realm of practice of any particular mental health discipline. In this way it aids in unifying the disciplines for a comprehensive approach to mental health problems.

4. Mental health consultation has been used successfully in numerous settings, ranging from traditional health agencies, through educational and corrections programs, to such new settings as minority and preschool programs.
5. The practice of mental health consultation helps in identifying research issues related to service delivery at the community level, as well as mental health disorders in the general population (rather than only in clinical populations).

Thus, mental health consultation can have a major and significant impact on the mental health field. It was to maintain the quality of care, and to develop an understanding of the wide amount of knowledge necessary to be an effective consultant, that mental health consultation has developed as a separate field. The present volume is particularly important, for it presents in a comprehensive manner the latest information and the vast body of literature in mental health consultation.

For those interested in mental health consultation, be they students, administrators, practitioners, researchers, or academicians, this volume offers a comprehensive resource with regard to theory, practice, training, and research. Although the field will change as new data and new ideas become integrated into theory and practice, this volume reflects the state of the art of mental health consultation as of the mid-1980s.

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PREFACE

This Handbook is the latest in a series of scientific papers, monographs, and books on mental health consultation developed or sponsored by the now-defunct Mental Health Study Center of the National Institute of Mental Health. The purpose of the series has been threefold: to assist community mental health centers and other mental health agencies in the planning, development, and evaluation of consultation; to provide technical resource materials for universities and other educational institutions in the development of training programs; and to stimulate research into the process, outcome, and impact of mental health consultation. Previous major publications in this series, which began in 1969, include the following (listed in chronological order):

Consultation in Mental Health and Related Fields: A Reference Guide, by Mannino, F.V. PHS Pub. No. 1920. Chevy Chase, Md.: NIMH, 1969.

Consultation Research in Mental Health and Related Fields: A Critical Review of the Literature, by Mannino, F.V., and Shore, M.F. PHS Pub. No. 2122. Washington, D.C.: U.S. Dept. of Health, Education and Welfare, 1971.

Task accomplishment and consultation outcome, by Mannino, F.V. Community Mental Health Journal 8(2):102-108, Mar. 1972.

Research in mental health consultation, by Mannino, F.V., and Shore, M.F. In: Golann, S.E., and Eisdorfer, C., eds. Handbook of Community Mental Health. New York: Appleton-Century-Crofts, 1972. pp. 755-777.

The Practice of Mental Health Consultation, by Mannino, F.V.; MacLennan, B.W.; and Shore, M.F. DHEW Pub. No. (ADM)74-112. Adelphi, Md.: Mental Health Study Center, NIMH, 1975.

The Effects of Consultation: A Review of Empirical Studies, by Mannino, F.V., and Shore, M.F. American Journal of Community Psychology 3(1):1-21, 1975.

Monitoring and Evaluating Mental Health Consultation and Education Services, by Mannino, F.V., and MacLennan, B.W. DHEW Pub. No. (ADM)77-550. Rockville, Md.: NIMH, 1978.

Evaluation of consultation: Problems and prospects, by Mannino, F.V., and Shore, M.F. In: Rogawski, A., ed. Mental Health Consultation in Community Settings: New Directions for Mental Health Services. No. 3. San Francisco: Jossey-Bass, 1979. pp. 99-114.

Mental Health Consultation, Theory, Practice and Research, 1973-1978: An Annotated Reference Guide, by Grady, M.A.; Storey, M.J.; and Trickett, E.J. DHHS Pub. No. (ADM)81-948. Adelphi, Md.: Mental Health Study Center, NIMH, 1981.

Trainee research in consultation: A study of doctoral dissertations, by Mannino, F.V., and Shore, M.F. In: Alpert, J., and Meyers, J., eds. Training in Consultation. Springfield, Ill.: Charles C. Thomas, 1983. pp. 185-203.

The present publication, Handbook of Mental Health Consultation, is a comprehensive reference source that is a culmination of the previous work. As such, it might be seen as a review of the field at the present time. However, it can also serve as a progress report that traces the development of the field to its current state and then, based on the current status, significant trends, and emerging themes, offers professional judgments regarding the major forces which may reshape the field in the future, along with some ideas as to the directions the future might take.

This book is dedicated to all of the former staff members, friends, and affiliates of the Mental Health Study Center, which for 35 years provided a real-life laboratory for the study and practice of community mental health, and to the members of the community in which it was located. The views expressed in this volume are those of the authors and editors; they do not necessarily reflect the official position of the National Institute of Mental Health or any other part of the U.S. Department of Health and Human Services.

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INTRODUCTION

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*combination
mixture* Mental health as a formal discipline of service and study is relatively new, its beginnings often traced back to the beginning of this century. Over time it has developed a large body of knowledge derived from work with individuals. This knowledge, an amalgam of social and behavioral sciences, has now been broadened to assist those in nonmental-health-related occupations--such as educators, industrialists, law enforcement personnel, etc.--to plan and develop programs targeting a variety of problems. Thus mental health consultation arose initially as a way of extending sound mental health principles into community organizations and agencies.

Over the past two to three decades mental health consultation has evolved from an individualistic approach dominated by clinical skills and psychotherapy techniques to a much more scientific, sophisticated, and rationally based field of specialization with a rapidly growing body of literature of its own. The literature includes a large number of research and evaluation studies, case books, experiential practice reports, and educational training materials. Advances in the field have led to new developments on several levels. Programmatically, the scope has widened to include work with many more community groups, e.g., preschool children, minority groups, and employee organizations; conceptually, several different models are now widely used, reflecting a more situational (person-environment) emphasis; and from a research standpoint, the quality and rigor of studies being reported has steadily increased.

Through our efforts as "chroniclers" of the consultation literature over the past 15 to 20 years, we have been able to monitor the development and direction of the field. Moreover, we have attempted to facilitate the continued growth of the field through the publication and dissemination of reference guides, analyses of the research literature, critiques, position papers, and research reports.

This enormous growth (and the continued diversity) in the field of mental health consultation, as well as the increase in the number of journals that have published articles dealing with mental health consultation, have made a handbook necessary at this time. To be sure, a number of books in the area of mental health consultation have been published, particularly in recent years. While some of these have become reference sources for

the field, most of them are not comprehensive. Rather they deal primarily with a particular discipline, setting, model, aspect of training, or population group. Thus, we have books that focus on schools, courts, psychology, social work, community, children, behavioral approaches, or the use of organizational development in consultation.

An assessment of the field showed there was a need for a comprehensive volume that could serve both as a reference text and as a secondary data source for the mental health field. Such a text should cover all aspects and dimensions of mental health consultation, e.g., research, training, settings, practice models, process, and professional and ethical issues. It should have an interdisciplinary perspective, embracing the developments and contributions from each of the core mental health disciplines. It should reflect the state of the art, but at the same time be written within a historical context. It should lead to suggestions for future directions. Most important, it should be empirically based, i.e., grounded in the research and practical experiences that have been reported in the literature.

This handbook, based on the above criteria, should prove to be a source useful for beginners, advanced practitioners, and students of the field alike. It should also point the way toward further areas of exploration for those who want to go beyond what has been accomplished to date.

Organization of the Handbook

As yet, there is little in the way of standards for practice and training in the field of mental health consultation. In fact, there is not even a universally accepted definition of consultation. Thus the reader will find various viewpoints in the chapters of this book. Any attempt at synthesis would have been a distortion of reality--for, at present, consultation is still much like a patchwork quilt in its final stages of completion. The various pieces are coming together to create a whole, but some of the connecting threads weaving through the various pieces toward an eventual goal of integration are still missing.

Nevertheless, in order to create an integrated product having some degree of internal consistency in subject matter, it seemed important that all the authors write from a common definitional framework. To accomplish this, this handbook uses the definition of mental health consultation found in the latest NIMH reference guide (Grady et al. 1981)--i.e., "a triadic interaction among consultant, consultee, and client involving indirect service and concerning some aspects of mental health."

Thus, two primary principles guided the development of this handbook: the defining characteristics just mentioned and the empirical base of the articles. Certain legitimate forms of consultation were excluded because they did not fall within the parameters of the above definition—for example, dyadic forms of consultation, consultation in direct service forms, and consultation without a mental health service component. This limitation was imposed to add some degree of clarity to the field and to avoid labeling and discussing dissimilar operations that are not truly forms of mental health consultation.

The second principle was to give preference to empirically supported methods, strategies, and techniques over activities having only anecdotal support, and to give the latter preference over those activities completely lacking any support at this time. Hence, insofar as possible, this volume is limited to material that has some foundation in knowledge (or at least a knowledge-based orientation) already reported in the literature. In this way knowledge and experience can be used to shape and design current and future practice. To some extent, therefore, this volume, as a state-of-the-art document, emphasizes what is known and the views and activities that are currently most prominent in the field. Although many new directions, innovative practices, and new approaches and paradigms are not included here, new areas are not totally ignored. The authors of the various chapters were encouraged to deal with emerging challenges and changes, and most have done so.

Following the course of development of the consultation literature, the book is divided into six major parts. Part I is a historical perspective which traces the development of mental health consultation from the beginning of the century to the present. Early origins and technical developments are documented, providing a clear picture of some of the antecedents of current consultation practice. Issues pertaining to consultation as a discipline and as a profession are discussed in the context of future growth and directions.

Part II presents the three major models of mental health consultation practice that are currently in use. In our review of consultation research some 15 years ago (Mannino and Shore 1972), we noted that the field was dominated by a commonsense approach, despite the rather natural applicability of several theoretical models. Considerable conceptual progress has been made since then: we see an increased use of psychodynamic theory, behavioral learning approaches, and organization development. Although other approaches are occasionally used, e.g., systems theory and ecological approaches, these have not yet

been widely incorporated into consultation practice and are not included.

In chapter 2, James et al. discuss mental health consultation from the psychodynamic perspective. The authors show how psychodynamic theory used as a framework to understand behavior can facilitate the use and implementation of a number of consultation practices and techniques. Variations on this theory, particularly interpersonal object relations approaches, are increasingly being used to supplement the classic theory.

Vernberg and Reppucci (chapter 3) analyze behavioral approaches to consultation using a broad conceptual backdrop that includes ecological and cognitive principles integrated with operant learning approaches to behavior change. They describe three different forms of behavioral consultation--i.e., case consultation, system consultation, and technology training--and conclude with a delineation of major challenges and issues pertaining to the process of consultation.

In chapter 4, Keys provides an overview of organization development, the third major approach to mental health consultation. He describes the basic assumptions, the strategies of intervention, and the research that has been done in this area.

Activities and contributions to consultation from each of the core mental health disciplines continue to play a significant, though everchanging, role in the development of the field. The papers in part III all focus primarily on problems, issues, contributions, and suggestions regarding future directions from the unique perspective of a particular mental health discipline. Schwab (chapter 5) reviews recent theoretical, educational, clinical, and research developments in an effort to evaluate the consultative roles and function of psychiatrists. Although he points to certain advances and refinements in consultation practice among psychiatrists, he concludes that political and social factors have actually curtailed and narrowed the psychiatrist/consultative role so that practice in the 1980s has returned full cycle to where it was in earlier years.

Robinson and Howard (chapter 6) present some of the key issues, dilemmas, and conflicts concerned with the professionalization of nurses and their effects on consultation relationships between nurses and other professional groups. As with psychiatry, nursing consultation also functions in a narrow way--mainly involving nurses providing consultation to other nurses.

The role of social work in consultation is covered in chapter 7 by Goldmeier and Mannino. These authors review the basic elements of consultation in social work as a distinct process and identify some of the issues and dilemmas of consultation stemming from general societal forces as well as from factors within the profession, such as ideological issues of goals and change.

Psychology's contributions to mental health consultation are delineated in chapter 8 by Conoley. She discusses some of the obstacles that hinder the growth of consultation in psychology as well as some of the major developments and contributions psychology has made, particularly to research and theory.

This section concludes with a discussion by Kelly (chapter 9) examining the heritage and philosophy of each of the core mental health disciplines and highlighting some of their major themes.

In contrast to part III which explores and defines discipline-specific issues, part IV presents information that cuts across disciplines. Here the concern is with processes, characteristics, ethics, training, organizational structures, and environmental contexts. The issues in this section are fundamental to consultation as a professional practice method. They call for greater cooperative efforts by all of the disciplines so that specialized interests and developments can be used to further the growth and advancement of the entire field.

Chapter 10, by Smith and Corse, describes the interplay of process issues at three levels: organizational processes, processes within the consultant system, and processes within the various exchanges specific to the consultation relationship. The stages of consultation common to most models are discussed, utilizing as a framework concepts of systems theory and framing. Smith and Corse also look to the future by applying three key conceptual trends--i.e., levels of change, parallel processes, and Cybernetics II--to the consultation relationship.

Chapter 11 on training--by Gallessich, Long, and Jennings--presents material on some of the major political, social, and technological forces influencing mental health consultation practice and subsequently traces their effects on developments in training. These authors identify trends and issues and consider critical questions regarding the training of mental health consultants.

In chapter 12, MacLennan deals with issues concerning the organization and delivery of mental health consultation services, fees, accountability, program evaluation, and the impact of the setting on organizational development and patterns of staffing.

Swift and Cooper (chapter 13) deal with the environment as a major variable to be considered by mental health consultants in their efforts to bring about change. They discuss critical variables that are part of the consultation environment (i.e., settings, consultees, and clients), and then present issues that cut across different consultation settings. These include goals, values, and lifestyles; administrative structure; and temporal factors.

Finally, Snow and Gersick (chapter 14) examine the ethical and professional practices encountered in consultation placing them within an ecological framework. They examine the unique ethical dilemmas which occur in major areas of consultation, underscoring their complexities and ambiguities. They also suggest ways to enforce and maintain ethical behavior in practice.

Part V is concerned with two related issues, research and evaluation, and the use of research findings in new areas of consultation. Whether we are concerned with disciplinary practices, conceptual orientations, social contexts, or organizational structures, the need for research is critical. Research and evaluation are necessary to assure accountability, to provide a rational approach to planning and delivering services, and to continuously upgrade and improve consultation as a valid method of mental health practice. In chapter 15, Kenney critically examines the research in mental health consultation, summarizing the findings and noting major research trends. He clarifies and depicts areas of need and suggests future research directions--for example, the need for diverse methodologies ranging from broad multivariate studies to closely controlled single-subject designs.

The second paper in this section (chapter 16) concerns the application of potentially useful research findings from other areas that are relevant to consultation and may serve as a basis for practice in new settings. This is the way consultation actually began--i.e., by borrowing clinical concepts and treatment techniques, altering them to meet the goals and requirements of consultation, and subsequently applying them to consultation program activities. In this chapter, Mitchell focuses on indigenous helpers or informal caregivers within human service systems. These include ordinary members of a community or neighborhood and such community gatekeepers as clergymen and lawyers. Mitchell reviews the empirical research and examines how the learning and use of helping behaviors are influenced by the social context. He elaborates on theoretical, research, and practical issues of this new area.

In the final paper (chapter 17) Levin, Trickett, and Kidder distill from the preceding papers a number of "overarching" themes which recur in the various topic areas and which represent

developing patterns and emerging approaches in the field. However, as in any new field, progress is not always clear with themes that are unambiguous, clearly understood, and widely accepted. Rather, as the authors point out, many different forces present frequently result in tensions stemming from complex issues and active concerns. They also point out a number of critical gaps in the field's evolution which are particularly resistant to an even course of progress. When linked with the broad themes mentioned above, all of these factors set the stage and promote the context for the future growth and development of the mental health consultation field.

The final part of the book contains an updated version of the consultation reference guide that was first published in 1969. It has been revised on two previous occasions. This third revision covers the mental health consultation literature from 1978 to 1984.

CODA - independent passage

The assumption underlying this volume is that mental health consultation has "come of age." As we look to the future at the many opportunities that will provide for the spread of mental health knowledge to other disciplines, it is essential that the large body of information regarding what is known be accumulated and evaluated so as to form a foundation for planning the future directions of mental health consultation.

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PART I

HISTORICAL PERSPECTIVE

CHAPTER 1

HISTORY AND DEVELOPMENT OF MENTAL HEALTH CONSULTATION

Fortune V. Mannino, Ph.D., and Milton F. Shore, Ph.D.

. . . when one knows the full history of development, one finds that what seemed to be a "first" was merely a repetition of something comparable that went before.

Ridenour--1961

Introduction

In the 1960s a paper dealing with the development of mental health consultation relationships with community agencies was submitted by the senior author of this paper to the Mental Hygiene Journal. The editor, George S. Stevenson, accepted the article, but reminded the author that many similar endeavors had been generated by the child guidance movement some 35 years earlier. It is sometimes necessary to jog our memories to help us realize that mental health consultation has a history and did not spring full blown out of the heads of Caplan, Berlin, and other leaders in the field after World War II. Indeed, the history of consultation includes a number of early pioneers whose work played a very important role in developing the foundation of mental health consultation as we know it today.

Early Years

1906 The roots of mental health consultation go back to Lightner Witmer's psychological clinic at the University of Pennsylvania in 1896 and to the visiting teacher concept that developed out of the settlement house movement around 1906.¹ Although the services provided were not called consultation, Witmer's concepts of diagnostic teaching and diagnostic education contained elements of a kind of "prescription consultation" wherein teachers carried out detailed recommendations for work with problem children. Visiting teachers, in their beginning years, were actually employed by settlement houses and carried out such diverse activities in the school as making suggestions concerning curriculum development,

cept - to elect/appoint as a fellow member.

school organization, and methods of teaching. Essentially, they employed a situational approach and served as agents of change, at least until they were coopted by the school system when they became professional clinicians, more concerned with providing direct service than effecting environmental change (Levine and Levine 1970).

1920s In the 1920s, two major forces were instrumental in the further development of mental health consultation. One was a professional group and the other primarily a lay group that combined both lay and professional leadership. Both groups worked closely together. The child guidance movement, the first of these forces, was an outgrowth of William Healy's Juvenile Psychopathic Institute in Chicago and the Commonwealth Fund's program for the prevention of juvenile delinquency. From their inception, child guidance clinics were seen as community agencies, playing a vital role in strengthening the community, identifying gaps in services, and working with the community toward correcting deficiencies. Child guidance practitioners always attempted to bring about a unified perspective on a community whereby every agency was seen as part of an interdependent community network, rather than as agencies that could exist and do a good job without regard for the quality of work done by other organizations in the community (Stevenson 1948).

Child guidance clinics, operating from the vantage point of the child within the context of the family and community, worked closely with community agencies toward effecting changes in community attitudes and transmitting mental health principles to improve the professional functioning of teachers, court personnel, social agencies, etc. As Stevenson and Smith point out (1934, p. 54), "The case and the community are the two foci of child guidance service, and whatever the clinic does may fairly be judged by its effect on both."

The National Committee for Mental Hygiene was the second major force instrumental in the development of mental health consultation in the 1920s. Organized by Clifford Beers, it fostered the mental hygiene movement, which used both lay and professional leaders to foster public education, legislation, and improvement of institutional facilities for the care of the mentally ill. The field work done by the National Committee for Mental Hygiene in the 1920s in consulting with local communities to facilitate the development of child guidance clinics was not unlike that performed later by the regional offices of the National Institute of Mental Health.

Both the child guidance clinics and the National Committee for Mental Hygiene were strongly committed to prevention as

well as treatment of mental illness and saw mental health services as entailing both the delivery of high-quality treatment and work with the community toward improving agency functioning and influencing public opinion.

The Technical Sophistication of the Early Years

In reviewing the historical literature, the technical sophistication of those involved in early mental health consultation activities (although they were not always labeled as such) is quite apparent. As mentioned, in the early years consultation services were primarily focused on developing and implementing the treatment of clinic patients. Most often the client was seen by the consultant who then worked with consultees from community agencies in carrying out a treatment plan. However, there were also efforts by consultants to go beyond the clinic's patients to educate and discuss material on patients and clients who were never seen at the clinic. In this manner, clinic staff would provide "direct consultation for workers at social agencies in order to bring their specialized view to bear upon the interpretation of case situations and the formulation of treatment plans" (Stevenson and Smith 1934, p. 105). Since the clinic had no direct contact with the child under discussion and took no part in either study or treatment, the cases considered did not appear in the client's record (Stevenson and Smith 1934).

An important goal of the child guidance clinics was to alter various environments (home, school, etc.) to make them easier or more pleasant places for the child to live. The techniques for accomplishing this goal were spelled out primarily for parents, but were also used with other individuals such as teachers, court officials, physicians, etc. Such techniques included (1) offering advice and suggestions (most commonly used with teachers); (2) providing "education"--a type of tutorial instruction regarding the emotional needs of children (Witmer 1940) used with parents and when consulting with local agencies; (3) providing support which was aimed at lessening anxiety and diverting some of their (primarily mothers') attention from their children's problems; (4) providing insight into parents' own personal problems; and (5) demonstrating procedures that could be adopted by school personnel without much modification through rendering services in a school in connection with problems of individual children. This approach was specifically mentioned in work with school personnel by Krugman (1948).

Not only were individual school teachers and agency personnel worked with, but agency staff were also seen in groups using such techniques as conferences, discussion groups, etc. These were

seen primarily as education for the staff and not specifically as consultation.

Expectations of Consultees

Witmer, in the 1920s, was very sensitive to concerns about usurping the functions of agencies and arousing resentment by having agencies become mere extensions of the clinic. At first the aim of child guidance clinics was to implement in other settings the recommendations made at clinic staff conferences--a strategy that meant teachers and child welfare workers had to function as psychiatric social workers. When this strategy failed, the child guidance clinics concluded it was not their job as consultants to make over other professionals into mental health professionals. They abandoned their efforts to turn community professionals into mental health professionals and abandoned the technique of interjecting mental health principles into case conferences which ostensibly had other purposes. Community workers in teaching, nursing, and welfare were accepted as functioning in their own capacity. Rather than trying to prescribe how such community workers should carry out their work, clinical personnel instead began providing information regarding each patient's capacities, handicaps, etc., so that the agency could determine how best to work with the child in line with its own mandates and functions (Witmer 1940).

Ridenour (1948) emphasizes that consultants to agencies need to be aware of what agency workers want from the mental health consultant. As she points out, agencies sometimes want what consultants are not able to give--such as a magic formula or excessive personal reassurance. She concludes that "more often than not, finding out what the other group really wants makes the consultant's job easier, not harder, and is worth considerable initial probing and later checking to discover whether they are getting it" (Ridenour 1948, p. 553).

Limitations of Consultation

Early awareness of the limitations of consultation were noted both by Witmer and Ridenour although they addressed different aspects of the issue. Witmer noted that the clinic must rigorously hold to the lines of its special function and ability in order to help community agencies further their work. She points out that one has to be extremely sensitive not to interfere with the functioning of other agencies, take over responsibility for their work, or try to train their staff to become therapists (Witmer 1940).

Ridenour (1948) speaks specifically to this training issue. She warns that mental health consultants should recognize the limitations of their training and must not spread themselves too thin. They should be aware of other related professions--their standards, goals, strengths, weaknesses, and special problems. For example, in medicine, the consultant must understand certain fundamentals in the physical care of children in order to consult meaningfully with doctors and nurses. Similarly, a mental health consultant who is trained to work with individuals may not have the experience to relate adequately to group problems in a classroom setting (Ridenour 1948).

Preparation for Consultation

Concern about proper preparation for consultation was realized very early. How much knowledge should an individual consultant have about the consultee agency prior to initiating a consultation? It seems clear that even in these early years preparation was seen as necessary. Mental health consultants must know something about each new field they attempt to serve. They must know the background and level of understanding of workers, and they must be able to grasp the special problems of the consultee's field so that they can offer practical suggestions that could be carried out by the agency (Ridenour 1948). In addition, Witmer (1940) notes the need for consultants to be knowledgeable about community resources so as to relate to other agencies. Kirkpatrick (1948) describes more generally the importance of understanding the community in which the individual works and the need to develop a perspective on community functioning and an appreciation for the interrelationships of various community agencies.

Organization, Administration, and Planning

Mental health workers in the community very early became aware of some of the problems in planning and implementing consultations. Stevenson and Smith (1934) noted the importance of child guidance clinics in influencing the standards of child care in the community and the importance of setting up concrete services illustrating the kinds of attitudes necessary to handle children. To illustrate this point of view, certain cases were selected for conferences with the community agencies to make mental hygiene concepts clear, and at the same time to make mental health issues more familiar to the community.

Ridenour (1948) points to the need for the consultant to be accepted by other agencies, with administrative sanctioning obtained at all levels within an agency in order to implement a program.

She mentions early concerns about consultation relationships, and the need for consultants to approach those they consulted with as competent professionals expecting their own experience to be enriched by such contacts. In addition, consultants needed to be sensitive to values different from their own and to understand the nature of these values. This value issue led Ridenour to differentiate two types of consultation. One involved consultation to related professions whose goals are at least partially similar to the goals of the psychiatric profession in that they are concerned with health, welfare, education, or some other aspects of personal and social adjustment. These related professions included the teaching and healing professions (medicine and nursing), and extended to law, personnel relations, and business and industry. The other type of consultation involved the interpretive professions—that is, those concerned with mass communications and entertainment. Interactions with this group involved more mental health education than consultation *per se*.

It was this separation between mental health education and consultation that Witmer seemed to be addressing in 1940 when she discussed the program of the California Department of Social Welfare. Witmer noted that the department did not present principles of mental hygiene in a systematic form and that it avoided professional concepts and terminology. This unsystematic presentation of materials seems to be closer to mental health consultation, while systematic planned programs that have as their goal information sharing might better be classified as mental health education.

Program Development Consultation

The National Committee for Mental Health began a type of program-oriented consultation in the 1920s. The Commonwealth Fund had started child guidance clinics in a number of cities which were models that many other communities wanted to emulate. The National Committee set up psychiatric field service teams to provide consultation to communities interested in organizing child guidance clinics (Ridenour 1961). This involved assessing the readiness of the community for establishing a clinic, strengthening community resources, if necessary, and generally helping to get the clinic underway (Stevenson 1948). Such resource consultation is similar to the way State and regional mental health offices operate today.

The consultant needed to know what was going on elsewhere in order to see the possible application of practices in one setting to another (Klein 1973). This was done by an ongoing program of

site visits to functioning clinics in order to keep abreast of what was happening. Stevenson (1948) points out that such site visits helped bring the experience of the field to bear in establishing new clinics, particularly in meeting problems of agency relationships, board functioning, qualifications of staff, finances, community education and development of related agencies. Sophisticated techniques were developed. Surveys were used to reveal gaps in community functions which needed to be dealt with before establishing a clinic. Problems were identified such as insufficient or inadequate probation staff, the absence of special provisions for individual children within schools, lack of recreational facilities, lack of a child-placement and foster-care agency, or lack of provision for the mentally retarded or for adult psychiatric problems. There was general recognition in the early years of child guidance clinics that these clinics could not be effective in a community that did not have basic resources. Therefore, the National Committee saw as a very important part of its task helping communities find solutions to these deficiencies as part of developing a child guidance center.

In addition to its survey, the National Committee displayed a high level of skill and sophistication in deciding when and how to consult. Thus, in these early years consultants recognized the need to determine whether a particular consultation would or would not strengthen the community. For example, requests by a community to organize a child guidance clinic were not accepted unless such a clinic would strengthen the community internally and did not merely increase the dependency of the community on outside help. The message to the community was clear: community leadership was necessary; if a group asked for help in strengthening itself so that it might assume such effective leadership, the consultation request was granted.

The Last 50 Years

Treatment-Oriented Focus

By the 1930s, a major change in direction was occurring--from a prevention-focused approach in mental health to one that was much more treatment-oriented. There are a number of hypotheses as to why this might have taken place. Some researchers speculate that the rise in psychoanalytic thinking in the United States and the focus on psychodynamics in individual intrapsychic processes tended to move professionals out of the community and into their offices. Caplan and Caplan (1967) mention two major pitfalls which provide clues to the weakening of the community/preventive movement. One was its tendency to excite too much

public enthusiasm and optimistic expectations--in other words, promising more than could be delivered. The other was its tendency to impose preconceived ideas on others; that is, to make others an adjunct in carrying out the functions of mental health professionals.

Musto (1975) talks of a decline in momentum behind social reform, and Weston (1975) mentions a lack of public and legislative support, as well as a concern on the part of professionals with more traditional care of mental illness. Levine and Levine (1970) suggest that the absence of technical know-how led to much frustration, and that the return to a more individualistic treatment-oriented approach may have resulted from that. In addition, we should remember that it was during the 1930s that insurance plans such as Blue Cross and Blue Shield arose, and although mental health benefits were not part of these early programs, they nevertheless set the stage for an illness/treatment service pattern which is still with us today.

Use of Consultation by the Military

During World War II mental health consultation activities seemed to increase, particularly in the armed forces. Ridenour (1961) describes a system of consultation where psychiatrists were assigned to each service command and theatre of war in the United States and abroad. These consultants had considerable influence on policy and program planning. One such example concerns the "NP" (neuropsychiatric) discharge. This type of discharge, which had a great stigma attached to it and often interfered with a person's finding employment, was abolished through the efforts of mental health consultants. Psychiatric consultants also played a significant role in the development of leadership programs and in the building of troop morale.

Greving and Rockmore (1951) have described a traditional case management consultation program in the military. Military social work staff, in the course of working with soldiers with adjustment difficulties, changed their way of working, spending more time outside of their offices. This permitted greater acquaintance with instructors, sergeants, line officers, and others who were immediately responsible for assignments in training. Thus, a military social worker was able to open new avenues and could discuss problems in management of individual soldier morale, AWOL rate, disciplinary problems, and other related matters. The social worker could also review the company roster and aid the commanding officer or the first sergeant in facilitating the handling of individual men in the unit. Thus, referrals to the mental health clinic were reduced. In some situations, the military social worker

was able to deal with soldiers who had just begun to show signs of breakdown, thus preventing a crisis later on. Social workers also sat in on sick call with medical officers in an infirmary and identified those soldiers whose emotional problems were beginning to manifest themselves in chronic and ill-defined physical and mental complaints. It is not clear how widespread this was in the military during the war, but this type of case management consultation was certainly used.

Prosser (1951) describes a type of program consultation in a military hospital. Consultation occurred with medical rehabilitation teams around issues such as systematizing referrals for physical training, educational services, occupational therapy, physical therapy, and work details. The consultant represented the psychiatric service of the hospital and was primarily concerned with the mental health aspects of the rehabilitation program, specifically the work detail. Consultants found, for example, that the work detail was assigned fairly indiscriminately, and as a result tended to exacerbate the symptoms of some patients while it helped others. The consultant made recommendations about the process by which men were to be assigned to a work detail. Likewise, procedures for patient participation in medical rehabilitation on a prescription basis were developed. Consultants worked closely with ward physicians to ensure that the various components of the rehabilitation program were presented in relation to a patient's total treatment. This permitted the resolution of differences of opinion, the adjustment of conflicting vested interests, and the development of communitywide approaches. After the program was developed and began operating smoothly, the consultant became less involved, but continued to give periodic consultations as needed.

The World Federation for Mental Health

International organizations were a major force for the growth of consultation shortly after the war. Beginning in 1948, consultation became an important function of the World Federation for Mental Health, an independent organization with close ties to the United Nations, which stressed the problems of prophylaxis and the role of interdisciplinary teams of social and behavioral scientists (Ridenour 1961). In 1955, the World Federation published a manual on technical change. Although it contained many insights of importance to mental health consultation, there is little indication of their utilization. For example, the manual indicates that when an individual or group is in crisis, the situation is more favorable for adaptive changes in beliefs, attitudes, and behaviors. Thus, crisis intervention was cited as an opportunity for constructive change. A second principle set forth in the Federation

document is that change sometimes will be accepted more easily if it is viewed in a new context. Only recently has this idea been adapted to mental health consultation.

The manual, endorsed by the United Nations Educational, Scientific, and Cultural Organization (UNESCO), offers examples of different kinds of consultation, although they are not labeled as such. For example, an entire chapter is devoted to the mental health implications of technical change (Mead 1955).

Adoption of the Public Health Model

World War II greatly accelerated the growth of mental health consultation. Shortly after the war, in 1946, the National Mental Health Act was passed and the following year the National Institute of Mental Health (NIMH) was created. The national program consisted of a three-pronged attack—research, training, and service underlying the integration of public health and mental health. Thus, one of the major aims of the early thrust was to merge the concepts and principles of public health with those of mental hygiene (Brown 1969). In the early 1920s, even though environmental change was emphasized, consultation primarily had its roots in a clinical frame of reference. By and large, for example, it relied on clinical case conferences to spread its effects into the community. With the passage of the National Mental Health Act, however, the public health model for the first time became a major determining factor in shaping the mental health movement and what is known today as community mental health. Public health concepts of primary, secondary, and tertiary prevention were translated into the language of the mental health profession, and mental health consultation and education became the chief mechanism for preventive intervention in the mental health area (Brown 1969). Even though the clinical model of case consultation was to continue as one of the most popular forms of mental health consultation, it also was incorporated into a public health model. It was believed, for example, that if consultation could heighten the sensitivity of community workers (e.g., teachers, ministers, nurses, and general practitioners) to the psychological and mental health aspects of their work, the front line of mental health defense would be shored up and maladjustments and mental illness could be reduced or prevented.

Caplan's Contribution

Many of the early ideas and developments underlying modern-day mental health consultation came from the work of the Lindemann-Massachusetts General Hospital-Wellesley group in the

late 1940s and early 1950s. Caplan became a part of that group in the 1950s and it is his name that is most often linked with the formalization, application, and elaboration of these ideas to mental health consultation (Ferneau and Klein 1969). Caplan was the first to write about and conceptualize consultation within a public health framework. In his first book to deal with consultation in a major way, he presented a pyramidal system of organization related to preventive mental health. In his system, members of the community who were experiencing difficulty were called "clients," and individuals whom the community designated to help those in difficulty were called "caretaking agents,"—e.g., teachers, clergymen, general practitioners, and nurses. Caplan viewed mental health professionals as the second layer of caretaking agents who provided help to the first layer through consultation. He hoped that this system would eventually have sufficient community coverage to be a major preventive force affecting the entire community (Caplan 1955). A third layer, of nonprofessionals, has been added by others to the two-layered pyramidal system outlined by Caplan. These are often termed "informal support groups" and consist of bartenders, hairdressers, janitors, taxi drivers, and such community workers as day-care personnel and after-care residential personnel. This group is significant because they serve as mediators between the client group and the professional world. Consultation to this group exemplifies the widening scope of the field over the years.²

Milbank Memorial Fund Conference of 1955

An historic event, the first national-level conference on mental health consultation, took place in 1955 under the sponsorship of the Milbank Memorial Fund. The proceedings of this conference were published as The Elements of a Community Mental Health Program (1956). Stimulated by the beginning growth of community mental health programming at the local level, the conference brought together leaders in the field to discuss various aspects of mental health consultation. Note should be made of the conference's obvious clinical psychiatric orientation to mental health consultation and the efforts in the conference to limit the field's boundaries. Thus, conferees made such statements as these: "It is probably not possible for anyone to act effectively as a full-time mental health consultant" (p. 17) and "Consultation on community organization matters cannot properly be regarded as mental health consultation" (p. 21). Nevertheless, the conference reflected great sensitivity to program consultation and to community problems and issues. Mercer's report (contained in the proceedings) may be one of the earliest reports on group approaches to mental health consultation.

The Federal Role

With the passage of the National Mental Health Act in 1946, Federal involvement in the field of mental health services became probably the single most important factor in the growth and progress of mental health consultation. The Community Mental Health Centers Act of 1963 listed mental health consultation and education as one of the five essential services necessary for such centers to qualify for Federal funds. An important part of the rationale for developing a true community mental health program was preventive mental health services. Thus community mental health center staffs were required to initiate communitywide exchanges on a routine basis with staffs of all relevant community agencies. This consultation and education requirement was the first time in any Federal health statute that a preventive service was declared mandatory (Yolles 1977). Since 1963, the Community Mental Health Centers legislation has been amended seven times, each time broadening its scope and extending new or additional coverage to various groups (Ochberg and Ozarin 1977). The amendments of 1970 and 1975 provided for even greater funding of mental health consultation programs (Mannino and Shore 1983a).

New Models

Coleman (1947) was one of the first to stress the importance of the role of the consultee in the development and perpetuation of a problem rather than seeing difficulties entirely within the client. Susselman (1950), Maddux (1950), Caplan (1955), and Berlin (1956) also addressed this area. Caplan's consultee-focused consultation, based on the theory of crisis intervention and psychodynamics, is a good example of the individual case consultation model. However, in recent years a number of newer models emphasizing more forcefully the man/environment interface has been formulated. These include social situational approaches to consultation (Levine 1972; Sarason et al. 1966), a behavioral model based on learning theories (Abidin 1972; Bellack and Franks 1975; Carver 1972; Winett 1976), the use of organizational theory (Schmuck 1976; Rand 1978; Mill 1974), and the application of an ecological approach (Kelly 1970; Dworkin and Dworkin 1975; Dworkin 1977). Although many of the above models continue to use an individual-focused intervention, the group approach to mental health consultation is now common. Organizational systems theory and ecological theory have broadened the scope beyond the individual to a much more interactional framework. These new theoretical orientations provide new conceptual bases for intervention, suggesting new strategies and new techniques. They represent a radical departure from the more traditional client-centered approach and

include the use of role modeling, systems modeling, openness, self-disclosure, free expression of feelings (Signell and Scott 1971), sensitivity groups, skill building, problem-solving skills (Keutzer et al. 1971; Schmuck 1968), token economies (Haring 1971; O'Leary and Becker 1967), and use of modeling procedures, both live and videotape models (Barclay 1970; Goodwin et al. 1971).

Training Programs

The first organized training program in mental health consultation appears to be that begun by Caplan in 1954 at the Harvard School of Public Health, Laboratory of Community Psychiatry. Other pioneering efforts were those of Viola Bernard at Columbia University School of Public Health, Portia Bell Hume at the California Department of Mental Hygiene in Berkeley, and Frank Tallman at the University of Southern California. Kern (1969) noted that these were the only recognized training programs until the beginning of the 1960s. Since that time there has been a significant increase in consultation training across all mental health disciplines, although most of the training seems to consist of courses rather than a fully developed consultation program. In 1969, Kern noted that NIMH was supporting at least 20 residency training programs in community psychiatry, all of which included some training in consultation. Training programs in community psychology and community mental health have increased from one in 1962 to 10 in 1967, 21 in 1974, and 62 in 1975 (Meyer and Gerard 1975). Courses in mental health consultation have also been included in many of the clinical psychology training programs. A study of social work training by Smith (1975) revealed that nearly one-third of the graduate schools offered courses in mental health consultation, and about the same number offered courses through their continuing education programs. Graduate training in psychiatric and mental health nursing is also increasing the amount of time allotted to field training in mental health consultation.

In addition to formal academic training across mental health disciplines, there has been an increase in sessions on mental health consultation at various national professional meetings, as well as special workshops and institutes sponsored by a variety of organizations. The chapter by Gallessich et al. in this volume as well as Gallessich's recent book (1982) contains excellent discussions of training patterns in consultation. In her book she indicates that training in mental health consultation is more developed than consultation training in other professions such as business and management. Some of the reasons she gives are professional leadership, demands for service, and theoretical elegance of the mental

health model and its potential for resolving problems (Gallessich 1982).

Research Studies

As with training, research in mental health consultation has shown remarkable gains over the past 10 to 15 years. The earliest research study found on mental health consultation per se was done by Kline and Cumings (1955). In a study which can still be regarded as unique, these authors compared two groups of public health nurse consultees to determine if there were any difference between them which could be related to the prediction of performance in a mental health education and consultation program. Since then the growth of research and evaluation has increased steadily.

A crude estimate of this growth can be found by counting the number of studies included in three consultation reference guides (bibliographic sources) published since 1969. The first (Mannino 1969) included all references to July 1968. It had 87 references categorized broadly as research out of a total of 646, about 14 percent. The second guide (Mannino and Robinson 1975), covering the period from July 1968 through 1972, contained 105 research references out of 490, or 21 percent. The most recent reference guide covering the period from 1973 to July 1978 had 243 research references out of 884, or 28 percent (Grady et al. 1981). These figures indicate the regular growth of the consultation field both in terms of research accomplishments and the more numerous practice and experiential type of articles.

This growth of consultation research is also reflected in the number of reviews done of the mental health consultation field. By 1984 we were able to locate 23 reviews ranging from reviews of the entire field (Osborn 1971) to reviews of subsections of the field such as consultation in child mental health (McClung and Stunden 1970) and school mental health (Medway 1979, 1982) to reviews which relate to the core mental health disciplines (Robinson 1982; McKegney and Beckhardt 1982; Kadushin 1977). Stretching over a period of 17 years, from 1967 to 1984, these reviews are a good representation of the overall growth and the areas of focus in the field (see Table 1).

Future Directions

What is the future for the field of mental health consultation? Is it a discipline or a profession? Or is it an interdisciplinary field of practice which combines characteristics of both?

Table 1. Reviews of Consultation Practice
and Research

| <u>Author</u> | <u>Date</u> | <u>Subject and Scope</u> |
|------------------------|-------------|---|
| Lipowski | 1967 | General principles in psychiatric consultation |
| Lipowski | 1967 | Clinical aspects of psychiatric consultation |
| Lipowski | 1968 | Theoretical issues in psychiatric consultation |
| Mannino | 1969 | Practice and research in mental health |
| McClung and Stunden | 1970 | Child mental health |
| Mannino and Shore | 1971 | Research in mental health and related fields |
| Oborn | 1971 | Overall field |
| Altrocchi | 1972 | Practice in mental health |
| Mannino and Shore | 1972 | Research in mental health |
| Mannino and Shore | 1975 | Outcome research in mental health |
| Carter and Cazares | 1976 | Practice in community mental health |
| Kadushin | 1977 | Research in mental health and social work |
| Bloom | 1977 | Selected research in mental health |
| Medway | 1979 | School consultation research |
| Meyers et al. | 1979 | School consultation research |
| Mannino and Shore | 1979 | Outcome research in mental health |
| Larsen | 1982 | Research in program/ technical assistance |
| Medway | 1982 | School consultation research |
| Robinson | 1982 | Psychiatric liaison nursing |
| McKegney and Beckhardt | 1982 | Research in consultation liaison psychiatry |
| Mannino and Shore | 1983b | Student research |
| Alpert and Yammer | 1983 | School consultation research |
| Medway and Updyke | 1985 | Outcome research |

Another series of questions stem from the "oughts." That is, if it is not yet a discipline or a profession, should it move in that direction? What are the gains and what are the losses? Are the gains greater than the losses?

In her recent book, The Profession and Practice of Consultation, Gallessich (1982) devotes several very thoughtful chapters to issues around the professionalization of consultation as a field. She points out that consultation is a major occupation of many individuals, that its practitioners are building and systematizing a body of knowledge and principles, that professional associations are being formed, and new practitioners are being taught. Applying the six criteria comprising Moore's (1970) scale of professionalization--(1) full-time, (2) a calling, i.e., lifelong commitment, (3) organization, (4) education, (5) service orientation, and (6) autonomy--Gallessich concludes that consultation has just begun to professionalize. Developmentally, she sees the field as having gone beyond the first stage, that of the established professions trying to meet the demands for new services by experimenting with practice modifications, to that of the second, the development of subspecialties of traditional professions. The third and final stage, creation of an independent field with its own normative patterns and principles, is the future direction that Gallessich sees for the field of consultation. To this end she includes a "Code of Ethics for Consultants," presented as an interim guideline, as well as training proposals for advanced study which are designed to prepare people for careers as independent professional consultants.

Levinson (1982) also discusses the issue of professionalizing consultation. He deals with it from the "ought" viewpoint and takes a strong stand that consultation should become a profession. He sees consultation as a generic discipline and discusses a proposed 2-year training period for those desiring to become consultants. As for the process of becoming a profession, he talks of people creating the foundation for a field out of their own experiences followed by translating their knowledge into academic disciplines which are then systematically taught in a more economical and logical way.

Levinson makes a distinction between consultation as a discipline and consultation as a profession. He considers it to be already a discipline that he believes should now be professionalized.

A review of the literature on disciplines by Burr and Leigh (1983) shows seven criteria which provide a basis for the analysis of consultation. Although there is some overlap with Moore's professionalization scale mentioned above, the discipline criteria are in the main quite different:

1. Unique subject matter. This refers to a subject matter that is relatively distinct from other disciplines. Since consultation is an activity that developed out of established disciplines chiefly because traditional modes of practice were not adequate to the problems nor to the service demands faced, it would seem that consultation does have a subject matter that has become sufficiently differentiated from its parent disciplines to be considered unique.
2. Adequate body of theory and research. The body of literature on consultation, as is reflected in Table 1, is sizable and continues to grow rapidly. Although there is still a long way to go, certainly we do see the beginnings of such a body of theory and research.
3. Unique methodology. Though consultation is still a new field of practice, its maturation does show an emphasis on selected methodologies. There are certain uniformities in problems and in ways of solving them.
4. Supporting paraphernalia. There is a solid beginning here, with a number of professional associations dealing with consultation practice (Gallessich 1982; Grant and Backer 1983), review papers, meetings, new journals arising, and courses of study planned or already underway.
5. Utility in the form of professions or applications. Consultation is an applied field whose very existence is the practical application of knowledge to social problems.
6. Discipline among the community of scholars. The issue here is whether the field can discipline the thinking and methods of study of people in the field. Consultation is still regarded as a subspecialty by most university-based training programs, but a few academic programs now have consultation as a major at the level of the master's degree, with movement toward work at the level of the doctorate (Gallessich 1982).
7. Belief that it exists. Is there consensus among professionals in the academic community that a discipline of consultation exists? Of all the criteria, this one is probably the weakest and will, in all likelihood, not be realized until there is greater recognition of and treatment by academic training programs of consultation as an independent field.

The conclusion from this analysis is that the field has a good beginning in meeting six of the seven criteria. It is probably not yet a discipline, but is certainly moving in the direction of becoming one, maybe within another decade.

As consultation moves toward becoming a profession and a discipline, it is important to consider in what ways the field will change. At the present time consultation is a practice method of several disciplines and subsections of disciplines. These include clinical, community, school, social, counseling, and industrial psychology; psychiatry and other medical specialties; management; social work; public health; sociology; education; nursing; and guidance and counseling. These 15 disciplines and subdisciplines all approach consultation from a particular perspective, contributing in multiple ways that no single discipline could. What might be lost to the field, then, when consultation becomes a single profession and discipline? Will these other disciplines continue to be attentive to the field, perhaps as consultant to the professional consultant? Or will there be a gradual dropping off of interest by the other disciplines? Another field of practice that probably would rate quite high on the aforementioned Moore scale of professionalization is psychotherapy, yet it continues to thrive as a subfield of a number of professions rather than as an independent profession. Has it grown and developed as a multidisciplinary field of practice at a faster and more even pace than it might have, had it become an independent profession? Or would it, perhaps, have not made much difference one way or the other? These are important issues which need to be faced if we are to provide guidance to the field of consultation as it continues to develop.

Summary

Mental health consultation, as we know it today, had its birth in the 1920s as a direct result of the activities of the child guidance movement and the National Committee for Mental Hygiene. Nurtured in an extended family, mental health consultation grew into an interdisciplinary mode. The roots of mental health consultation are firmly imbedded in prevention. From its beginning, concepts of mental health consultation were aimed at influencing others by transmitting sound principles of mental hygiene. Its main role was that of being an agent for change in the community.

At first, intervention occurred at the community level among groups closely associated with mental health such as school-teachers, pediatricians, nurses, welfare workers, probation officers, and clergymen. Its early use of clinically oriented techniques served as a bridge between the individual and environmental forces

which were seen as having a significant influence on individual behavior. Later, changing the environment was seen as an effective way of positively affecting the mental health of the individual.

From its earliest beginnings, mental health consultation focused on individual and community strengths, rather than on weaknesses, and on enhancing and facilitating supports rather than on treatment and dependency. Thus, mental health consultation has from its very beginning been accountable to the community (and other agencies), while treatment was accountable to the patient.

Mental health consultation over the years has stressed training in community functioning and the interrelationship of community agencies. Clearly mental health consultation should not just be seen as an "add on" function or professional activity aimed at resolving manpower issues, or as a stopgap measure, but as inherently valuable in itself as a significant method for changing people's behavior, improving their functioning, and reducing later maladjustment and future mental health problems. Mental health consultation has developed, particularly over the last two decades, a strong body of descriptive and empirical knowledge. In fact, one can see mental health consultation as a major fulcrum in the development of community mental health services. Even though the fiscal retrenchment that is presently occurring has slowed this development, it has not lessened the importance of mental health consultation. Its viability lies not in its connection to any one method or level of care, but in its functional relation to all service levels (prevention, treatment, and rehabilitation), and in its flexible use of program requirements which emphasize coordination and integration of services.

Notes

1. This paper does not deal with medical consultation. For those interested, an excellent account of the history of consultation in the field of medicine may be found in a chapter by A. Kutzik titled "The Medical Field," in Supervision, Consultation, and Staff Training in the Helping Professions, by F.W. Kaslow and Associates (San Francisco: Jossey-Bass, 1977).
2. However, even consultation to nonprofessionals is not without historical precedence. According to Lourie, Clifford Beers acted as a consumer-participant in the early 1900s by offering treatment to troubled people while receiving consultation from the professional staff of the Connecticut Society of Mental Health (see Lourie, R. The polygamous state of mental health. Connecticut Medicine 41:37-46, 1977).

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PART II

MAJOR MODELS AND ORIENTATIONS

CHAPTER 2

TRADITIONAL MENTAL HEALTH CONSULTATION: THE PSYCHODYNAMIC PERSPECTIVE

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Mental health consultation continues to be recognized as a major intervention strategy for dealing with problems in human relations. Both logistic and manpower considerations have impacted greatly upon theorists, practitioners, and researchers in the human service fields with respect to the development of effective and efficient methods for the prevention and treatment of human relations problems. These considerations are thought to be fundamental to the growth and popularity of consultation as a viable intervention strategy and are well reflected in the ever-increasing literature pertaining to mental health consultation. While many papers refer to a field of consultation, the term "mental health consultation" is currently used to describe a variety of models or approaches. Each model or approach is based on a relatively distinct theoretical perspective and, as such, does not yet lend itself to a desired level of integration.

The purpose of this chapter is to discuss one particularly salient model, labeled here as traditional mental health consultation. Traditional mental health consultation is based on a psychodynamic perspective and primarily involves the application of psychodynamic concepts to an indirect service process as articulated by Caplan (1964, 1970), Berlin (1964, 1967), Bindman (1959, 1966), Berkowitz (1968, 1973), Newman (1967), Altrocchi (Altrocchi et al. 1965; Altrocchi 1972) and others. The psychodynamic perspective, by definition, focuses on cognitive and affective processes and the effects of these processes on interactions within and between individuals in interpersonal situations. Inherent to this perspective are such issues as (1) conscious, preconscious, and unconscious motivations; (2) transference and countertransference; (3) distorted perceptions based on intrapsychic forces; (4) defensive maneuverings to cope with anxiety; (5) resistances to change; (6) projection and displacement mechanisms; and (7) ambivalence and conflict.

In the early years, the majority of mental health consultations were carried out by mental health professionals trained as psychoanalysts or in psychoanalytic theory. The psychodynamic

perspective was therefore quite naturally used in understanding the consultation situation irrespective of whether the consultant functioned as an expert, as an information resource, or as a colleague to assist others whose fields were not mental health. Only in certain basic forms of consultation where it was used for diagnosis and treatment recommendations did it take on the characteristics of a model. For the purposes of this chapter, however, it is seen as a perspective in which any number of consultation practices or techniques can be subsumed and implemented.

Development

Roots

Traditional mental health consultation grew out of the medical model of clinical work in which the psychiatrist saw the patient of another physician. The focus was always on the diagnosis and treatment of the patient. Consultation was essentially a direct service process during which one physician, acting as consultee, requested advice or evaluation services from another physician, acting as consultant, regarding a difficult or problematic patient. From a mental health standpoint, the rationale for this type of consultation was the increased work efficiency of the consultee physician upon being relieved of the problems and conflicts of these difficult and troublesome patients (Kurpius and Robinson 1978).

During the 1940s, psychoanalytically trained psychiatrists and other mental health professionals began to move out of hospitals and clinics into community settings. This was often done at the request of schools, public health nurses, and public welfare and family service agencies. At first, the mental health professionals were asked only to diagnose and treat certain referred clients. However, when the caseloads for treatment became too large, they began to switch to secondary rather than primary patient care. That is, the mental health professionals stopped seeing patients directly and, instead, would see the patient's therapist or the client's contact person. These sessions were early efforts at mental health consultation. The mental health professional, acting as consultant, collected data from the agency worker, acting as consultee, and then attempted to assist the consultee in deciding what might be done to help the client.

A major development in mental health consultation resulted from Coleman's (1947, 1956) work with a public welfare agency where he encountered caseworkers struggling with very troubled

and troublesome clients. Over a period of time he came to realize that he could best assist by focusing on the consultee's relationship with these troublesome clients and the consultee's feelings about the clients. This inclusion of the consultee in the problem-solving process was a milestone in the development of mental health consultation. It opened up a process in which the consultees could discuss their feelings, concerns, and problems and thereby facilitate and improve their work effectiveness.

Caplan (1956, 1959), who had been working as a psychiatrist in a youth program in Israel, further advanced the progress of mental health consultation when he came to the United States and began to systematically study the consultation process. Caplan (1963) had first obtained his experience consulting with children's residential centers in Israel. Noting the inability of his psychiatric staff to meet the individual needs of the large number of children in these centers, he began to develop a process by which the needs of the children could be met utilizing the staff of those centers. At about the same time, Lindemann was working in a Massachusetts school system observing children in classes, and his resulting observations led to conclusions similar to those of Caplan (1970).

This striking finding that consultation be regarded not as psychotherapy, but as an indirect method once removed from the clients who needed the help, led the psychodynamically trained mental health professional to look not only at intrapsychic factors, but at social and interpersonal factors as well. While at first the consultants focused on the appropriate diagnosis and treatment of the client, they soon changed to a focus on the interactions between the consultees and their clients. Still later, they found it necessary to focus on the interactions between the consultant and the consultee as well.

This new conception of consultation, centering around the consultee's problems in the context of the client's environment, has become one of the most popular forms of consultation and has come to be regarded as the traditional mental health consultation model. It has been viewed as having great potential for promoting mental health and preventing mental illness. It has also been viewed as being just as relevant, if not more so, at the levels of treatment and rehabilitation.

Psychodynamic Influences

The majority of consultation principles and techniques derived from psychodynamic concepts can be attributed to Caplan. While his more recent thinking is described in some detail in The Theory

and Practice of Mental Health Consultation published in 1970, earlier publications show the evolution of his ideas as they developed over time. Caplan first presented his ideas about consultation at a conference held at the University of California School of Social Welfare in June 1955. He began there to articulate his conceptual framework for what is now known as "theme interference reduction," but which back in 1955 was called "crisis consultation," or "dissipating the stereotype."

In this particular technique, the consultee is thought to be thrown into disequilibrium by the client's problem. The consultee perceives the client as a stereotype of the consultee's own emotional problem, to which the consultee may react by anxiety, excessive blame, or rejection. Thus, in psychodynamic terms, the consultee attempts to handle the problem vicariously through projection and displacement onto the client. The goal of this interference reduction is to allow consultees to make maximum use of their professional skills undisturbed and unhampered by unresolved personality problems. This is achieved through an ego-supportive relationship wherein the consultant serves as an accessory ego figure and as an additional superego and ego-ideal figure with whom the consultee can identify.

The consultant then supports the consultee, while the consultee assists the clients in their difficulties. This process not only alleviates the client's problems but, since clients' problems are linked to the consultee's own difficulties, it often leads to improved mental health and decreased tension on the part of the consultee. In this fashion, the same mechanism which originally caused the consultee to be upset in relation to the client's problem later helps the consultee derive vicarious benefits from the client's success. Thus, consultees master their own problems through helping clients who have similar problems.

Probably the most widely used technique in psychodynamically oriented mental health consultation today is Caplan's technique of theme interference reduction, which is a direct derivative, elaboration, and refinement of dissipating the stereotype. As stated by Altrocchi (1972), theme interference reduction "is the most detailed, complex, and subtle mental health consultation technique" (p. 495) and is usually used as part of consultee-centered case consultation, one of Caplan's four consultation types (described later in this paper). It too is based on the consultant's understanding of the consultee's problems as resulting from intrapsychic conflicts.

Theme interference, as defined specifically by Caplan (1970), involves unresolved personal problems (past or present) that are displaced onto task situations, producing temporary ineffectuality

and loss of emotional stability in dealing with a segment of the work field. Signs that a theme is interfering with effective work with clients and peers can be identified when the problem is assessed. Significant signs include (1) repetitive difficulty with a particular problem, (2) confusion, (3) anxious, emotional reactions, and (4) erratic and inappropriate responses. The client's behavior arouses the anxiety of the consultee because the consultee has similar unresolved conflicts. This concept clearly parallels the psychodynamic concept of transference, as do the two mechanisms for resolution--unlinking the theme and theme interference reduction.

To reduce theme interference, the consultant does not focus on the unresolved conflicts, but rather on the effects of the conflicts on the consultee's way of perceiving the client. Caplan (1970) suggests four indirect techniques that can be used in theme reduction. Here the consultant and the consultee discuss the problem during which the consultant demonstrates alternative outcomes to the negative consequences envisaged by the consultee. The second technique involves the use of a parable, and is appropriate for dealing with especially sensitive themes. In using this technique, the consultant diverts discussion away from the client toward a case that appears completely different, but retains essential theme elements. The third technique involves nonverbal focus on the case. After demonstrating the consultant's understanding of the difficulties of the problem, the consultant remains calm and relaxed so as to nonverbally show that the doom expected by the consultee is not likely to happen. The final technique involves nonverbal focus on the consultation relationship. Here the interaction between the consultee and consultant parallels that between the consultee and the client. By the way the consultee relates to the consultant, the consultant is able to see the theme. The consultant then manipulates the relationship with the consultee so as to invalidate the dire consequences the consultee expects.

Berlin (1969) also discusses how transference, countertransference, and resistance can interfere with the consultation process. When transference occurs, the consultee reacts as if the consultant were an authority figure from the consultee's past. The result may be irrational anger that the consultant does not "give enough," or is "too demanding" in the collaborative work. Thus, dependency is often a transference issue. Conversely, when some aspect of the consulting situation reminds the consultant of authority figures in the consultant's past, the phenomenon is called countertransference. For example, school consultation may remind the consultant of a past experience with an authority figure such as a principal, teacher, or coach. Resistance by the consultant or the consultee to collaboration in the consultation

experience may impede the process. The way consultants deal with these issues serves as a model for consultees in dealing with their clients.

Types of Consultation

Caplan's Classification Scheme

Although approaches to consultation can be classified in a variety of ways, mental health consultation approaches have historically been differentiated by Caplan's (1964, 1970) fourfold classification scheme and the distinction between individual and group consultation. Recent literature has supported Altrocchi's (1972) assertion that only these differentiations have attained general usage in the field. For example, Hirschowitz (1973) and Rogawski (1978) have summarized Caplan's classification scheme which until recently only acknowledged an individual approach to consultation. In addition, Meyers, Martin, and Hyman (1977) have differentiated various writings on the basis of an individual or group approach to consultation.

According to Rogawski (1978), Caplan differentiated consultations by content and focus. Differentiation by content includes case consultation and administrative consultation. In the former type, the consultant is asked to evaluate, discuss, and make recommendations about a specific case, whereas in the latter type the consultant considers the mental health implications of a program or policies of an organization. Differentiation by focus includes client- or program-centered consultation and consultee-centered consultation. In the former type, the consultant deals directly with the client or program, whereas in the latter type the consultant works with the consultee to indirectly impact on the client system.

In many instances, client-centered case consultation and program-centered administrative consultation involve direct service from consultant to client. In some instances, however, these types involve indirect service from consultant to client through the consultee. Examples are combinations of client-centered and consultee-centered consultation in which the consultant might observe, or even briefly interview, the client to facilitate the consultant's work with the consultee. While there is direct contact between the client and the consultant, no service is provided by the consultant. Program consultation is different in that the professional is called in to consult about problems in programs that relate to mental health services. Although the consultant may make a special assessment of program needs,

recommend a plan of action, and perhaps even consult about implementation, the ultimate beneficiaries of the consultation are the consumers or recipients of the program's services.

No matter what type of consultation approach is employed, the psychodynamically oriented consultant is always guided by a clinical attitude which is tuned to the here and now (Singh 1971). The consultant observes, listens, questions, and continuously watches for hints and clues as to what is going on. Through this process the consultant begins to develop inferences as to what dynamic forces are operating and how these forces are influencing the client's functioning. This gives the consultant an understanding or explanation of the problem which can be used in formulating an appropriate intervention plan.

Group Consultation

In keeping with the above philosophy, Altrocchi, Spielberger, and Eisdorfer (1965) expanded individual mental health consultation principles to include groups. The group approach, while maximizing the effectiveness of the consultant, can be used in all four types of consultation. Advocates of the group approach suggest that the consultant use a variety of techniques associated with the roles of teacher, group leader, clinician, and communication facilitator. Essentially, this approach involves group discussion of the consultees' reactions to and feelings about their clients as well as the active use of group process by the consultant. The consultees' affective involvement with clients are generally considered with respect to current work problems.

In describing his altered perspective toward group consultation, Caplan (Plog and Ahmed 1977) outlines several important principles which group members learn as a function of the opportunity to alternate roles from consultee to co-consultant within the group setting. First, the consultees learn to recognize and deal with the normal tendency to stereotype by discovering how to broaden their views regarding expectations for behavior and subsequent consequences. Second, consultees learn to understand the most inexplicable human behavior by gathering sufficient information to provide additional options for problem solutions. Third, consultees learn an increased tolerance for feelings in clients and in themselves, but not necessarily through discussions which focus on feelings. Fourth, group members come to realize the value of calm, methodical analysis and therefore learn to avoid premature closure of judgment and action. Finally, the range of intervention possibilities which evolves in group consultation increases feelings of personal mastery for most consultees, which in turn increases feelings of self-mastery and self-esteem.

The decision to use an individual or group approach is influenced by the defined circumstances under which either approach is applicable or appropriate. Despite the contention that group consultation represents a more efficient use of a consultant's time, provides more cues and hypotheses for the consultant, and provides more support for group members, Altrocchi, Spielberger, and Eisdorfer (1965) note that group consultation also removes a group of consultees from a work situation simultaneously, demands a mutual time for group meetings, assumes that consultees are able to present work problems in a group context, and requires group cohesiveness to be effective.

Consultation Process

The process of consultation from the traditional or psychodynamic perspective involves a sequence of steps which take place over a period of time. The consultant must first establish a contract with the agency and define how, where, and when the consultation is to take place and how much it is to cost. Secondly, the consultant and the consultee must spend some time getting acquainted and to allow for some reduction of both of their anxieties. The third step is the beginning of the problem-solving relationship and the use of various techniques to accomplish this. The fourth and final step is concerned with disengagement and evaluation.

While each of the above steps is viewed as equally important to the effectiveness of the consultation, literature within the psychodynamic framework has tended to focus on the process by which the consultant and the consultee define the problem and generate solutions to the problem. According to Caplan (1964, 1970), the consultant employs well-developed diagnostic interviewing skills to determine if the problem reflects a lack of knowledge, skill, self-confidence, or objectivity on the part of the consultee. The consultant then employs intervention techniques which are selected on the basis of the problem definition.

Rogawski (1978) has most recently suggested that the lack of knowledge, skill, or self-confidence can be handled effectively by educational or nonspecific supportive measures. However, the lack of professional objectivity usually requires that the consultant recognize and deal with the consultee's preconceived and often unconscious themes which interfere with effective problem-solving capabilities. As discussed in more detail previously, the primary technique for dealing with lack of objectivity is theme interference reduction. This technique is based on the assumption that the consultee projects or displaces aspects of the consultee's own psychological issues onto the client, and involves indirect as

opposed to direct interpretation of the consultee's thoughts, feelings, or actions in an effort to respect the separation of the work-related role and the private life of the consultee.

There are, therefore, certain characteristics of the therapeutic relationship which can be useful in establishing a relationship between consultant and consultee. The use of clinical skills, especially the ability to listen with a "third ear," i.e., to be sensitive to symbolic meanings and to recognize verbally unexpressed, unconscious material, is invaluable. However, in addition to such basic clinical skills, consultants also need to have a clear understanding of their role in the nontherapeutic relationship. To build and maintain a successful consultative relationship, the consultant functions differently from a therapist.

The differences between consultation and psychotherapy have received a great deal of attention in the literature, and have been most recently summarized by Plog and Ahmed (1977, p. 4-6). These differences are described as conclusions drawn from actual practice and include the following:

1. Mental health consultation requires the professional providing the services to have a broader array of skills and capabilities than is required of an individual in private practice.
2. The typical consultant must be much more flexible and professionally adaptable than the average individual engaged in psychotherapy.
3. Mental health consultants must be prepared for the shock of having their services evaluated. Most psychotherapists, operating behind closed doors, are far more insulated from professional or lay evaluation of the quality of their work.
4. Consultants typically have to be responsive to the sociological setting in which they are operating as well as the personal psychology of the individuals with whom they are consulting.
5. Because of their awareness of the social milieu in which they work, the vast majority of mental health consultants have a deep respect for the establishment.
6. Consultants and their clients have coequal professional status.

7. Mental health consultants generally have to be much more emotionally stable and far better "put together" than therapists in private practice.

As suggested above, the consultant must see the consultee as a peer or colleague rather than as a patient. The relationship between consultant and consultee is based on mutual dependency. However, the consultant must still be aware of the psychodynamic issues as necessary for change to occur. The consultee selects the subjects to be discussed and, to some extent, must direct the discussion. The rationale for this is that only issues that make sense to the consultee or appear to be problems to the consultee will be heard and accepted. Later, the consultee begins to depend upon the consultant for cognitive guidance and perhaps for emotional support as well. The consultant has the responsibility of giving information, relating to the consultee in a supportive manner, and generally being able to give what the consultee asks of the consultant, always in the context of the dynamics of the consultation process. At the same time, the consultant must be keenly aware of and work toward preventing the consultee from feeling intimidated and losing self-respect.

Another issue involves the mental health consultant's relationship to the status quo. Plog and Ahmed (1977) have specified that consultants need to be responsive to the sociological setting in which they are operating. Moreover, they have asserted that consultants must learn to work within the situational realities and to generate solutions to problems which reflect these realities in order to achieve "acceptable final outcomes." They have suggested that this sensitivity to social milieu allows the consultant a deeper respect for the establishment. Yet, this notion would appear to have developed from the traditional mental health consultant's alliance with and respect for persons in positions of responsibility within the variety of consultation settings. For example, Core and Lima (1972) have discussed the importance of acknowledging the authoritative structure of a probation department and supporting agency policy when consulting to juvenile court systems, while Gustafson (1976) has described a mode for defense of the status quo in a small group or institution. While most consultants would agree that it is indeed important to recognize persons in authority, recent literature has indicated that serving the establishment does not necessarily produce reasonable outcomes for the clients involved.

Berlin (1975) has examined obstacles to involvement at the community level when traditional mental health consultation is applied to the school setting. He contends that traditional mental health professionals involved in school consultation often cannot think in terms of community needs because they are employed by

the schools, are often in competition with each other, and therefore seek power by serving the educational establishment. In order to better serve the client system, he advocates a reorganization of the role of the mental health professional around prevention which would include using one's professional expertise on behalf of the community and placing one's skills at the disposal of the community, parents, and student. This is not to say that mental health consultants ignore the impact of systemic change on the hierarchy. Instead, Berlin has suggested that consultants help community participants and school personnel anticipate and deal with resulting political and social resistance:

Mental health consultants need to be in constant touch with key people in the schools and the community who will be subject to the greatest pressure, the most anxiety, and in some instances even threats, so that they can be supported through this onslaught and be helped to maintain their position despite pressure to revert to the status quo (Berlin 1975, p. 206).

Thus, in this role the mental health consultant serves as an advocate for the community and its schoolchildren and therefore serves the consultee in solving present and future difficulties regarding the client system.

Future Directions

Recent literature pertaining to the field of mental health consultation continues to support much of the previous writings on the traditional model (Grady et al. 1981). The most significant change overall is the recognition of alternate models or approaches which go beyond the traditional conceptualization. The behavioral and organization development models have received a great deal of attention in recent years, as have various systems approaches and other approaches to consultation. Within the traditional model, interventions which provide consultee- or client-centered case approaches to individual consultees, or increasingly, to a group of consultees (e.g., Berkowitz 1974; Spielberger 1974; Shulman 1975) continue to play a dominant role in the field.

Consultee- or program-centered administrative consultations seem to be used somewhat less frequently than forms of consultee- and client-centered consultations. Because few consultants utilizing a psychodynamic perspective are as knowledgeable about administrative issues as about mental health issues, they tend to focus on the interpersonal and group dynamic aspects of the

presenting problem. Yet, as noted by Caplan (1964, 1970), traditional consultants who do have training in administrative issues contend that clinical approaches to administrative issues are often equally if not more useful than approaches offered by administrative specialists (e.g., Levinson 1983). In addition, consultee- and program-centered administrative consultations are thought to be especially effective in the promotion of community mental health because of their potential impact on organizational and systemwide changes which affect individual functioning. With the ever-increasing concern for prevention and the importance of systemic change, consultee- and program-centered administrative consultations are likely to continue to expand.

Recent literature also indicates that mental health consultants come from a variety of professional disciplines and consult in a variety of settings. Despite this trend, most of the literature pertaining to the traditional model continues to focus on consultation-liaison psychiatry in the hospital or other medical settings. A number of articles describe the application of traditional psychodynamic concepts to the consultation-liaison experience (e.g., Krell et al. 1975; Janssen 1978; Hyland and Book 1981; Manos 1981; Perry and Viederman 1981), and one very interesting article describes the application of concepts from ego psychology, an extension of traditional psychodynamic theory (Mohl and Burnstein 1982).

The application of concepts from ego psychology will likely continue to expand as will applications from other related theoretical perspectives such as transactional analysis (e.g., Brown 1976; Hover 1976; Freeman 1979), rationale-emotive therapy (e.g., Forman 1978), and gestalt therapy (e.g., Kettler 1979). Articles which focus on consultation-liaison psychiatry in medical settings will also continue to appear in relatively large numbers because of psychiatrists' concern about their role in the health system and the integration of mental health and health services (Braceland 1978; Pasnau 1982).

Research on traditional mental health consultation reflects a somewhat different trend. The majority of recent research pertaining to the traditional model attempts to evaluate the effectiveness of Caplan's consultation approaches or types in educational settings. Several of these research studies focus on the consultee-centered case approach, usually in comparison to other traditional approaches or another model such as the behavioral model (e.g., Woody 1974; Meyers 1975; Wenger 1976). In addition, two recent dissertations and one article focus on the effectiveness of consultee-centered administrative consultation (Carr 1976; Birney 1977; Ford 1977). Another recent study focuses on the frequency that a consultee's problem is due to a lack of

objectivity as opposed to knowledge, skill, or self-confidence as perceived by school psychologists acting as consultants, and reports that very few problems are thought to be the result of lack of objectivity (Gutkin 1981).

The bulk of research efforts will probably continue to take place in educational settings primarily because so many psychologists practice in these settings. However, it would be beneficial if researchers paid even closer attention to basic issues of experimental design and became more programmatic in terms of design and implementation. It would also be beneficial if more research efforts were to take place in the increasingly numerous other settings where traditional consultants practice (Rogawski 1979).

Not especially apparent at the present time is a trend toward integration of mental health consultation models and approaches. As noted previously, psychodynamically oriented consultation has been expanded to include related theoretical perspectives such as ego psychology, but has not really been integrated with behavioral and organization development models or systems approaches to consultation. Yet, Berlin (Plog and Ahmed 1977) has advocated the expansion of traditional consultation to include behavioral methodology, and Gallessich (1976) and Alpert (Alpert and Trachtman 1978) have included aspects of traditional, organization development, and systems models or approaches as conceptual bases for school consultation. In addition, recent books have discussed the traditional model in conjunction with other major models and approaches (e.g., Meyers et al. 1977; Gallessich 1982; Cooper and Hodges 1983), but these books have not provided much in the way of integration.

It would be beneficial if the future literature would provide greater integration of consultation models and approaches both at the levels of theoretical perspective and techniques for actual practice. Although the traditional model has been primarily based on individually oriented psychodynamic concepts, it has expanded over the years to include a focus on groups and administrative issues. As this model continues to expand, it will overlap increasingly with other models and approaches focusing on environmental, organizational, and systems variables. It is at this interface that a more useful integration of mental health consultation models and approaches will probably be formulated.

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CHAPTER 3

BEHAVIORAL CONSULTATION

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The term "behavioral consultation" enjoys wide and general use in the psychological and educational literature. Activities labeled (or potentially labeled) as behavioral consultation have been employed in a wide variety of settings, including schools (Bergan 1977; Hughes 1980; Jason and Ferone 1978), homes (Baker and Heifetz 1976; Matese et al. 1982), mental hospitals (Jeger and McClure 1982), juvenile correctional facilities (Reppucci and Saunders 1974), public areas (Jason et al. 1979), residential treatment schools (Luiselli 1981), community mental health centers (Bellack and Franks 1975), nursing homes (MacDonald and Butler 1974), and industrial settings (Luthans and Kreitner 1975; Pedalino and Gamboa 1974; O'Brien et al. 1982). The range of issues addressed by behavioral consultation activities is equally broad--from increasing academic performance to increasing pro-social behavior, from decreasing dog litter in parks to decreasing delinquent behaviors, from language training to weight control. The targets of change range in ecological complexity from individuals to groups to organizations to communities to societies (cf. Glenwick and Jason 1980). Moreover, the recipients of the service cut across the entire life cycle from young children to the elderly. Even (or perhaps especially) the conceptual framework guiding behavioral consultation efforts has become diffuse, as principles from ecological and cognitive traditions have been integrated with operant learning approaches to behavior change (Nietzel et al. 1977; Jeger and Slotnick 1982a).

Obviously, to provide a thorough review of behavioral consultation is beyond the scope of this chapter (see Gallessich 1982; Glenwick and Jason 1980; Gutkin and Curtis 1982; Heller and Monahan 1977; Jeger and Slotnick 1982a; Kazdin 1982a; Keller 1981; Medway 1979; Nietzel et al. 1977; Tombari and Davis 1979, for review of various aspects of behavioral consultation). Indeed, to provide thorough coverage in a single chapter to even a subset of behavioral consultation research and practices, such as those conducted in a specific setting (e.g., schools) with a specific population (e.g., elementary age children) from a particular behavioral perspective (e.g., behavioral-ecological) would be excessive. For these reasons we have chosen a set of more modest goals: (a) to define some broad boundaries for the term "behavioral consultation"; (b) to describe briefly its various

forms--behavioral case consultation, behavioral system consultation, and behavioral technology training; and (c) to provide an overview of current challenges.

Boundaries, Concepts, and Assumptions

Defining the exact boundaries of behavioral consultation is a difficult task, as authors have presented various and sundry schemata that overlap to some degree but retain unique aspects (Bergan 1977; Bernstein 1982; Jeger and Slotnick 1982b). The operational boundaries accepted for present purposes synthesize elements of existing models to include mental health interventions characterized by (1) the utilization of indirect service delivery models, (2) a reliance on behavioral technology principles to design, implement, and assess consultative interventions, (3) a diversity of intervention goals ranging from solving problematic situations to competency enhancement to empowerment, (4) changes aimed at varying levels of ecological complexity (i.e., individuals, groups, organizations, and communities) and breadth (i.e., from single settings to multiple settings). While this is an admittedly broad standard, it is adopted for several reasons: (1) to dispel the view of behavioral consultation as an operant learning-dominated model; (2) to move the discussion beyond the client-centered case consultation (Caplan 1970) that seems to dominate many descriptions of behavioral consultation (Bergan 1977; Russell 1978; Tombari and Davis 1979); and (3) to acknowledge the conceptual restrictions inherent in problem-focused orientations (cf. Rappaport 1981).

Indirect Service

The emphasis on indirect service reflects a view of behavioral consultation as a procedure for disseminating insights gained from behavioral research and theory to a degree not attainable through direct services. In essence, indirect service signifies that the consultant seeks to bring about changes in the clients' functioning by influencing the behavior of the service providers who have direct contact with the clients or by making systemic changes in settings in which the clients participate (Reppucci and Saunders 1983).

The most popular models of indirect service used by behavioral consultants to bring about these changes may be divided into three categories. The first is behavioral case consultation which occurs when direct contact personnel (e.g., teachers, mental hospital attendants, or parents) interact with a behavioral consultant to consider the handling or management of a specific client or

group of clients. The second is behavioral system consultation in which the relationships existing between various aspects of a specific system are analyzed and modified in light of behavioral technology principles. This mode of indirect service could also include analysis and modification of relationships between two or more systems, such as school and family systems (e.g., Tharp and Wetzel 1969). A third model is behavioral technology training. This model is used when the goal of the behavioral consultant is to increase the degree to which direct contact personnel utilize behavioral technology principles when interacting with clients in general. Activities such as behaviorally oriented child management training for teachers (e.g., Winett et al. 1976) or parents (e.g., Baker and Heifetz 1976) would fall into this category.

Each of these types of indirect service is intended to bring about changes in client functioning even though the scope of analysis and intervention varies considerably across types. Moreover, reality often dictates that a behavioral consultant provide more than one type of indirect service in the course of a consultative relationship. Further discussion of each of the categories of behavioral consultation will be presented in later sections of this paper, along with a summary of relevant research findings.

Behavioral Technology Principles

As previously noted, the task of defining basic assumptions of behavioral consultation has become more difficult as the early behavior modification model based primarily on principles of operant conditioning, classical conditioning, and observational learning/modeling has been integrated with ecological and cognitive theory (Jeger 1979; Jeger and Slotnick 1982a). Extensive discussions of the conceptual foundations of behavioral theory relevant to behavioral consultation are available elsewhere (Jeger and Slotnick 1982a; Keller 1981) and will be reviewed only briefly here. An underlying assumption is that all behaviors, including those labeled abnormal, are developed and maintained both quantitatively and qualitatively by the same laws of learning. Moreover, these laws of learning can provide a framework for understanding and action regarding the acquisition or development of dysfunctional behavior and the maintenance of inappropriate behavior once established (Tharp and Wetzel 1969).

Operant conditioning emphasizes the role of environmental consequences in shaping and maintaining behaviors. Many techniques and principles utilized by behavioral consultants owe a great deal to the operant tradition, including extinction, timeout, response cost, shaping, prompting, contracting, and token economy systems (see Bandura 1969).

Classical conditioning emphasizes learning that occurs from the repeated pairing of conditioned and unconditioned stimuli. Principles and techniques derived from classical conditioning that are potentially of use to behavioral consultants include reciprocal inhibition (i.e., decreasing the strength of a conditioned response by eliciting an incompatible response to the same conditioned stimulus), stimulus generalization, relaxation training, and covert sensitization. These techniques, however, are more likely to be utilized in direct rather than indirect service delivery situations (see O'Leary and Wilson 1975).

Observational learning/modeling stresses learning that takes place from observing the behavior of others. Modeling is thought to produce learning by allowing observers to acquire primarily symbolic representations of the modeled activities, which in turn serve as guides for appropriate performance (Bandura 1977). In the context of behavioral consultation, modeling is often used to demonstrate new behavior sequences to consultees, such as attending to appropriate behavior and ignoring inappropriate child behaviors in a classroom. Other applications of modeling, such as participant modeling and covert modeling, have been used widely in direct service relationships, but are seldom described in the behavioral consultation literature.

Behavioral ecology views individuals as embedded in a multi-layered ecological environment (Willems 1974). The settings in which an individual participates are seen as interdependent to varying degrees, and the possibility of spillover or side effects of interventions becomes worthy of investigation (Wahler et al. 1979; Wahler and Fox 1981; Willems 1974). In relation to behavioral consultation, behavioral ecology stresses the need to consider the fit between proposed interventions and the characteristics of the individuals and settings involved, and the need to expand the focus of most interventions beyond a single setting if meaningful changes are to occur.

The cognitive-behavioral perspective emphasizes the role of cognitive variables in determining behavior. Cognitions are seen as behaviors, albeit nonpublic and covert, subject to the same learning principles as overt behaviors and thus modifiable by the same sorts of behavioral techniques used to modify overt behaviors (Meichenbaum 1977). The influence of this conceptual framework is most apparent in the behavior therapy literature (Mahoney 1974; Meichenbaum 1977; Miller and Berman 1983), but reports of cognitive-behavioral approaches to case consultation are beginning to appear (Rhode et al. 1983). In addition, cognitive-behavioral techniques such as social problem-solving training have been employed in preventive interventions that fall within the

boundaries of behavioral consultation (Elias et al. 1982; Spivak et al. 1976; see Hops 1983, for a recent review).

Intervention Goals

Problem solving has often been described as the goal of behavioral consultation (Bergan 1977). Problem solving is a useful construct to describe the traditional model in which the consultant is viewed as an expert who possesses the knowledge and authority to define the problem and provide the proper solution. However, although a clear-cut solution may exist in some quite specific individual cases, problem solving becomes a less appropriate goal as attention to ecological complexity increases. The likelihood that a right answer to a problem exists decreases; instead, a variety of viable but possibly contradictory solutions exist (Rappaport 1981). To embrace problem solving as the consultant's goal (and domain), according to this view, is to impose conceptual restrictions on the range of possible solutions. This in turn leads in too many instances to interventions that fail to have their desired effects. An alternative goal when operating from a perspective that acknowledges ecological complexity has been labeled "empowerment" (Rappaport 1981), and bespeaks of collaborative rather than expert/helper relationships:

By empowerment I mean that our aim should be to enhance the possibilities for people to control their own lives. If this is our aim then we will necessarily find ourselves questioning both our public policy and our role relationships to dependent people. We will not be able to settle for a public policy which limits us to programs we design, operate, or package for social agencies to use on people, because it will require that the form and the meta communications as well as the content be consistent with empowerment. We will, should we take empowerment seriously, no longer be able to see people as simply children in need or as only citizens with rights, but rather as full human beings who have both rights and needs. We will confront the paradox that even the people most incompetent, in need, and apparently unable to function, require, just as you and I do, more rather than less control over their own lives; and that fostering more control does not necessarily mean ignoring them. Empowerment presses a different set of metaphors upon us. It is a way of thinking that lends itself to a clearer sense of the divergent nature of social problems (Rappaport 1981, p. 15).

Empowerment as a goal for behavioral consultation is at present not widely accepted. Nevertheless, the issues and values represented by this construct are important to consider, especially as

behavioral scientists (e.g., behavioral community psychologists) attempt to intervene at levels of greater ecological complexity and breadth.

Levels of Intervention

Depending upon the goals of consultation, interventions vary in the level of organizational complexity at which they are aimed. Along this dimension, a distinction may be made among targets for change, ranging from individuals to groups to organizations to communities. Behavioral consultation has been directed most frequently at the individual or small group level, as in case consultation projects or the usual behavioral technology training. However, more wide-ranging targets for change have been selected from time to time involving entire organizations (e.g., Reppucci and Saunders 1974) and communities (e.g., Kinkade 1972). A related distinction exists in terms of the ecological scope of consultative interventions. The conceptualization of individuals embedded in an ecosystem ranging in complexity from a single setting to a system of settings (i.e., all or a portion of the settings in which an individual participates) to a greater context in which the system of settings exists (i.e., the community or culture) is useful in making this differentiation (cf. Bronfenbrenner 1979). The various parts of the ecosystem are thought to be inter-related, with changes in one part producing changes in the others.

Within a given level of organizational complexity, variations in the ecological scope of interventions occur. At the individual level, for example, an intervention may be intended to influence a client's behavior in only a single setting, such as the classroom. Alternatively, an attempt may be made to effect changes in a client's behavior across a variety of settings, such as the classroom, the playground, and the home. The bulk of the behavioral consultation literature describes single-setting interventions, although cross-setting changes have received recent attention in the behavior therapy literature (Wahler and Graves 1983).

Summary of Principles and Practices

In light of the diverse settings, levels of intervention, and conceptual perspectives utilized by behaviorally oriented change agents, the list of principles and practices common to all behavioral consultants is necessarily brief: (1) both adaptive and maladaptive behaviors are acquired and maintained through the same learning processes; (2) maladaptive behaviors can be modified through the appropriate application of learning theory; (3) successful interventions should lead to observable changes in

behavior; and (4) empirical evaluation of intervention effects is essential.

In the sections to follow, information pertaining to the variety of activities that fall under the rubric of behavioral consultation will be presented. The material is organized in accordance with the three-category typology (behavioral case consultation, behavioral system consultation, and behavioral technology training) presented previously. Within this typology, behavioral principles, intervention goals, and levels of intervention are also discussed.

Behavioral Case Consultation

In behavioral case consultation, the consultant interacts with direct contact personnel to consider the handling or management of a specific client or group of clients. Several models have been presented in the literature (e.g., Bergan 1977; Goodwin and Coates 1976; Russell 1978). In spite of the wide and varied application of behavioral consultation approaches, these models vary little in general form and several authors have suggested the same basic procedure is used regardless of the setting or target for changes (Russell 1978; Tombari and Davis 1979).

Probably the most detailed model for conducting and describing behavioral case consultation has been advanced by Bergan and his colleagues (Bergan 1977; Bergan and Tombari 1976; Bergan et al. 1980). This model consists of four sequentially ordered stages: problem identification, problem analysis, plan implementation, and problem evaluation. Problem identification involves the specification of the problem or problems to be solved in consultation. Problem analysis involves the identification of factors maintaining the problem behavior and the development of a plan to solve the problem. During the plan implementation stage, the consultee attempts to carry out the intervention developed during the previous stage. The problem evaluation stage requires the assessment of the effectiveness of the intervention. This model is not new in form; in fact, the stages bear a strong resemblance to Lewin's action research model (Lewin 1946) and to general problem-solving approaches to consultation (Gutkin and Curtis 1982). Nevertheless, the specification of how to accomplish each stage from a behavioral change perspective is useful and will be presented in some detail.

Problem Identification

The goal of problem identification is to specify the problem to be solved during consultation. This component appears at first glance to be quite simple, but potentially may be the most difficult and important task facing a consultant (Gutkin and Curtis 1982). How the problem is defined dictates plans for resolution. Moreover, in a study of behavioral consultation in the schools (Bergan and Tombari 1976), the chances of continuing a consultative relationship or attaining a solution to the problem were found to decrease dramatically when this phase was not completed promptly following referral.

It is incumbent on the consultant during this phase to evaluate whether the presenting problem is maladaptive for the client or merely distressing to the consultee (cf. Winett and Winkler 1972). Several discussions of criteria for determining whether a behavior should be targeted for change are available (e.g., Blackman and Silberman 1975; Davison and Stuart 1975; Stolz et al. 1975), with the basic decision resting on consideration of the best interests of the client (e.g., American Psychological Association 1981). If the decision is made to proceed (and this should not always be taken for granted [Reppucci 1977]), specific objectives during this phase include: (a) precise behavioral definitions of the client's problem; (b) goals stated in performance terms; and (c) strategy to collect baseline data (Tombari and Davis 1979).

Problem Analysis

In this phase, the consultant seeks to identify factors maintaining the problem behavior and to develop an intervention plan. A basic distinction is often made between whether a particular problem is due to conditions surrounding the behavior or to a lack of individual skills required to behave as desired (Bergan 1977). Large variability in performance is thought to indicate a conditions component, while continuously poor performance in the presence of an environment supportive of the desired behaviors is often characteristic of skill deficits (Tombari and Davis 1979).

Several detailed descriptions of procedures for conducting behavioral analysis in the context of behavioral consultation are available (Bergan 1977; Goodwin and Coates 1976). These approaches focus strictly on analysis of overt behavior, leaving them open to criticism from cognitive behaviorists who argue for the analysis of covert behaviors (i.e., thinking) accompanying overt behavior sequences (Meichenbaum 1977) and from ecological behaviorists who argue that behaviors occurring in one setting are influenced by conditions existing or events that have occurred in

other settings in which the individual participates (Wahler and Fox 1981). The integration of these concepts with basic applied behavior analysis procedures is proceeding, albeit slowly. A concise procedure for problem analysis in the context of behavioral case consultation influenced by these movements has yet to appear.

The schema used during the analysis phase dictates the types of interventions selected by the consultant. Given the restricted focus of the most popular analysis procedures, it is not surprising that most individual case reports and larger-scale outcome studies of behavioral consultation have described interventions limited in scope to the operant conditioning of overt behaviors. While the published studies have almost all shown at least a temporary improvement in some target behavior, charges of limited generalization (both in terms of transfer and maintenance) of changes have persisted (Wahler and Graves 1983). Broadening the range of factors considered during behavior analysis seems likely to result in consultative interventions involving cognitive-behavioral and cross-setting manipulations.

Plan Implementation

The consultee bears primary responsibility for the direct implementation of the intervention plan. Thus, a key task is to design interventions consistent with the strengths and weaknesses of the consultees and the settings in which they operate. A good fit between the consultee and the intervention depends on both the presence and requisite knowledge and skills, and the absence of organizational or administrative barriers to implementation. A behaviorally sophisticated teacher, for example, may not be able to implement a full-scale token-reinforcement intervention due to a lack of clerical help, supplies, or administrative flexibility. Similarly, a teacher or other direct care person biased against behavioral approaches may not implement a plan presented in behavioral terminology regardless of available resources (Reppucci and Saunders 1974).

The consultant must also monitor this phase carefully to assure the intervention is carried out as planned (Kazdin 1982a; Sechrest et al. 1979). Continuous data collection and supervision have been found in numerous instances to be crucial for maintaining the integrity of interventions (Kazdin 1982a).

Problem Evaluation

The primary issue addressed during the evaluation phase is the extent to which the objectives established during problem

identification were met. Behavioral consultation generally results in a more objective assessment of behavioral changes than do other approaches to consultation. At the same time, subjective ratings of success have traditionally been downplayed. This has led at times to charges that behavioral consultation often results in changes noticeable only to the consultant (Tombari and Davis 1979). Similarly, the cost of the intervention in terms of the consultee's time and energy is seldom considered along with the objective behavioral changes in reports of behavioral case consultation projects. In the same vein, side effects of behavioral intervention for the clients are seldom addressed systematically, although, as pointed out by Wahler and Fox (1981), evidence of both positive (Koegel et al. 1974; Strain et al. 1976; Wahler and Fox 1980) and negative (Sajwaj et al. 1972; Wahler and Fox 1980) side effects has been found. Failure to address these issues during the problem evaluation phase may increase the probability of discontinuation of the intervention or a deterioration of its integrity.

A related set of pertinent issues involves analysis of the generalizability of behavioral changes across time and ecological settings. While this topic is too broad and complex for detailed consideration here, a few comments are in order. First, transfer and maintenance of change have seldom been addressed in the behavioral consultation literature *per se*. Judging from outcome studies of more direct service behavioral interventions, generalizability may be enhanced under certain conditions. For token-economy interventions, strategies include:

... removing the token economy gradually so that behaviors are maintained with less direct reinforcement; reinforcing behaviors under a variety of situations so that the behaviors are not restricted to a limited range of cues; substituting naturally occurring reinforcers such as praise and activities in place of tokens; altering the schedule and delay of reinforcement to prolong extinction; and using peers and clients themselves as reinforcing agents to sustain long-term performance across a variety of situations . . . (Kazdin 1982a, p. 437).

Second, much of the appeal of cognitive-behavioral and behavioral-ecological interventions lies in the promise of enhanced generalizability. Once again, there are few data in the behavioral consultation literature itself to assess how successful these approaches may be in producing long-term, generalized effects. Direct service interventions using these approaches have produced evidence of generalizable effects under certain conditions. For cognitive-behavioral interventions with children, these include longer-term involvement in treatment programs and rehearsal of specific cognitive skills in controlled settings until

mastery is attained, followed by practice in more natural settings (Hops 1983). For behavioral-ecological interventions, few direct data are available, although the suggestion is made that changes must be made in contingencies between stimuli and an individual's behavior across settings, rather than in just one setting, if maintenance and transfer are to occur (Wahler and Graves 1983). Specific techniques to accomplish this task are as yet poorly defined.

Behavioral System Consultation

In behavioral system consultation, the process and structure of a social system are analyzed and modified in accordance with behavioral technology principles. The general goal is to enhance a given system's effectiveness in fulfilling its various functions. In many ways, this approach is similar to the more ecologically oriented types of behavioral case consultation discussed earlier. In fact, the behavioral systems approach for interventions with school social systems presented by Maher (1981) proposed a sequence of steps very similar to Bergan's consultation model, proceeding from system-level problem definition to system-level evaluation. A key distinction between behavioral system consultation and behavioral case consultation lies in the focus of the process and structure of a system per se in the former versus a focus on a particular individual's (or group of individuals') relation to a system in the latter.

With the increased acceptance of a more ecological perspective among behaviorally oriented consultants (e.g., Krasner 1979; Reppucci 1977; Willems 1974) and its emphasis on understanding the complex interrelationships and interdependence within and between organism-behavior-environment systems, these concerns have begun to be recognized as crucial for the successful implementation of behavior modification programs in natural settings. The goal of systems change requires: (1) an understanding of both historical and environmental context, (2) a focus on the creation of a growth-producing and motivating environment for both staff and clients, and (3) serious consideration of problems of innovation, implementation, and organizational structure (Reppucci and Saunders 1983). We will concentrate our attention on this last set of problems, not because they are more important than the former two, but because they have been the most emphasized by behavioral systems consultants. (For a fuller discussion of systems change in human service organizations in general, see Brager and Holloway 1978; Goodstein 1978; Reppucci and Saunders 1983.)

Behavioral consultants have usually become involved with social system interventions in response to dysfunction in ongoing institutions (Reppucci 1973) or as planners in the creation of new

settings (Twardosz and Risley 1982). We focus here on a set of implementation issues proposed by Reppucci and Saunders (1974) and Reppucci (1977) that were derived from their behavioral systems intervention at a correctional facility for adjudicated delinquent boys and which have been used as a framework for subsequent interventions (e.g., Jeger and McClure 1982). Ten implementation issues were identified and warrant brief review:

1. Institutional constraints. Bureaucratic barriers or "red tape" which characterize most settings often work against system changes. These constraints frequently include limitations on the redistribution of reinforcers and make consistent alterations of behavioral contingencies difficult if not impossible. For example, in the correctional facility intervention (Reppucci and Saunders 1974), an attempt was made to change a work-for-pay program into one which would conform to an established behavioral point system. However, although administrators and staff agreed that it was a positive idea and would be helpful to the boys, it was not implemented because the top administrator suggested that any change in the program necessitated approval by the state legislature and the business office insisted that it could not become involved in exchanging points for money.

2. External pressure. Political realities or external pressure often result from economic, political, or administrative considerations. Unfortunately, they may force changes other than those proposed by the behavioral consultant. For example, in the correctional change project (Reppucci and Saunders 1974), several judges in the community brought pressure to bear on the institution's superintendent to keep the delinquents in the facility and out of the community for longer periods than the behavioral rehabilitation program considered reasonable or justifiable.

3. Language. Choosing a vocabulary to describe behavioral technology principles that avoids the negative reactions often aroused by the technical jargon is important. The aversive image associated with terms such as "behavior modification" may result in resistance to implementation of behavioral programs (Saunders and Reppucci 1978).

4. Two populations. Difficulties often arise from the consultant's lack of direct implementation of behavioral technology. The consultant has little direct control over the contingencies of reinforcement to which the target clients are actually exposed because the consultant has little or no contact with the client. The consultant may design the program, oversee its implementation, and even monitor its effects, but the indigenous staff (e.g., nurses, aides, teachers, and correctional officers) are ultimately responsible for executing it. Thus, the consultant can influence

the behavior of the target individuals only by influencing the behavior of the staff mediators (Tharp and Wetzel 1969). This is a complicated task. In most settings, the major contingencies that may influence staff (e.g., salaries, promotions, and job security) are under the control of unions, the civil service merit system, personnel departments, tenure, or politics.

5. Existing institutional staff. Related to the problem of two populations is the fact that in any established setting, a staff already exists that may or may not be supportive of a consultant's efforts. In all probability, many of these staff will have a longevity that far exceeds the consultant's. Depending upon the goals (e.g., establishment of a special behavioral program within an institution or conversion of an entire institution), it is essential that existing staff, to a greater or lesser extent, become involved in the project. The staff should not be ignored. One way to ensure involvement is to seek input from all levels of staff regarding their institution and to use this input to develop and implement a program tailored to their setting. Not only will the consultant learn invaluable information about organizational and interpersonal dynamics, but also the consultant will be laying the foundation for ownership of the program with the individuals who will actually implement it. (For an example of how this was done is one instance, see Reppucci and Saunders 1978; Wilkinson et al. 1974).

6. The port-of-entry problem. During the initial stages of any consultation, the consultant is inevitably viewed with suspicion and as a source of possible conflict. Is the consultant competent? What does the consultant want? How will the changes affect us? All of these questions and many more will be in the minds of the existing staff, and successful negotiation of the port-of-entry period by the consultant is necessary for any likelihood of an effective intervention.

7. Limited resources. Limited finances, time, and personnel are the norm, not the exception, in most natural settings. There is a frequent lack of sufficient quantities of desired reinforcers for both staff and clients.

8. Labeling. The labels used to describe organizational activities are often inexact and value-laden, e.g., education, recreation, therapy, and rehabilitation. At times, any of these activities can serve functions that are of negative value from the standpoint of an overall behavioral system. For example, in the correctional change intervention mentioned earlier (Reppucci and Saunders 1974), staff members were often unwilling to follow agreed-upon rules for contingent participation when activities were labeled

as "educational," thus diluting the effects of the behavioral strategies.

9. Perceived inflexibility. The problem of attaining flexibility within a theoretical context refers to the conflict which arises from the goal of consistency derived from behavioral theory juxtaposed against the press to make exceptions to the rules. Denial of access to some desirable activities may lead system members to view behavioral consultants as rigid, and behavioral interventions as overly restrictive and inflexible.

10. Compromise. There are inevitable compromises that must be made between behavioral principles and the reality of natural settings. The concept of compromise addresses the probability that the behavioral systems consultant will, over the long run, be influenced by the contingencies operating in the natural environment. Constant reappraisal of the values implied by system interventions is necessary in order to remain true to the personal and professional ethics of the consultant.

A behavioral system consultant must recognize and appreciate that all settings are sociopolitical entities and that implementation issues, such as those described above, must be attended to seriously. The predictable effects of behavioral approaches under carefully controlled conditions are just not possible in natural environments. Nevertheless, attention to systems issues has the potential of increasing the likelihood of success. As Thompson and Grabowski (1972) point out in reference to a hospital:

A state hospital consists of bricks, mortar, beds, and many thousands of over-stuffed file folders; but, more importantly, it is a very complex social system. Yet, if one is to have any success in implementing a therapeutic program within a state hospital, he must attempt to come to grips with the system (p. 269).

A behavioral system approach attempts to fulfill this mandate.

Behavioral Technology Training

Teaching specific behavioral technology skills or general behavioral principles to consultees has been an objective for many behavioral interventions. There are several reasons for providing this training. First, it has been demonstrated that consultees who apply behavioral techniques are effective in changing problematic client behaviors in many instances. Obviously, these techniques

must be taught to the consultee as a first step. Second, a firm understanding of social learning principles seems likely to increase the probability that behavioral programs or techniques will be carried out as intended (Tharp and Wetzel 1969). Thus, program integrity should be enhanced when the persons charged with carrying out an intervention understand the reason why each component is important (McMahon et al. 1981). A third major reason centers around generalizability (Forehand and Atkeson 1977). Consultees who attain a thorough familiarity and understanding of behavioral techniques (e.g., systematic analysis of behavior, selective attention, timeout) and behavioral principles (e.g., characteristics of positive and negative reinforcement, shaping, extinction, and punishment) seem more likely to incorporate behavioral approaches into their day-to-day activities, thus increasing their effectiveness as behavior managers and decreasing client problems. This increased effectiveness, it is hoped, will reinforce the consultee's use of behavioral technology, leading the consultee to apply behavioral solutions to new problems that arise (cf. Baer and Wolf 1970). Finally, behavioral technology training is seen as a potentially cost-effective and efficient means to disseminate mental health expertise to large numbers of people.

While these reasons for providing behavioral training to consultees all have considerable apparent validity, empirical support for all but the first reason cited is somewhat scanty. Moreover, the first reason--the effectiveness of consultees applying behavioral techniques in changing client behaviors--while well supported empirically, is also worthy of closer examination. Major issues include what techniques are effective for which problems under what conditions. This section defines several factors to consider when designing or carrying out behavioral technology training.

Selective Application

A considerable body of experimental literature supports the assertion that behavioral technology training for consultees leads to improvements in client behavior. This has been shown clearly, for example, in behavioral training programs for parents of developmentally delayed children (Baker 1976; Brightman et al. 1982; Johnson and Katz 1973) and conduct-disordered children (Patterson et al. 1982; Wells and Forehand 1981). It is also clear, however, that meaningful changes in client or consultee behavior occur for only a moderate proportion of participants (Baker et al. 1980; Griest and Wells 1983). Recognition of this fact has led to increasing concern with the identification of variables to predict the likely outcome of behavioral technology training for individual participants (Clark et al. 1982; Griest and Wells 1983).

In the relatively standardized training programs (i.e., each program follows a standard curriculum) used by Baker and his colleagues, socioeconomic indices (e.g., income and education) and mothers' teaching skills and experience before entering the program correlated with short-term outcome, while the parents' performance during training (e.g., attendance and involvement) was the best predictor of long-term followthrough (Clark et al. 1982). These authors suggested prediction criteria should be used to match prospective participants with the appropriate intervention program as a means to make the most of limited resources. For example, those parents likely to require more intensive or long-term attention would not go through the short-term training programs, while the likely "high success" candidates would not receive more training and attention than necessary.

In their summary of behavioral technology training for parents of conduct-disordered children, Griest and Wells (1983) also stress the need for the selective application of parent training programs. They identified several aspects other than child management skills to consider when deciding which parents should receive behavior management training only, including the parents' cognitive, psychological, marital, and social adjustment. In an intriguing bit of postulation, the authors offered a tentative breakdown of referrals to child outpatient clinics into three groups and defined subsequent implications for parent training:

1) behaviorally and/or emotionally deviant children whose parents' perceptions are accurately based on their child's behavior, 2) children who are behaviorally and/or emotionally deviant but whose parents' perceptions are also influenced by their own maladjustment, and 3) relatively normal children whose parents' perceptions are inaccurate and are based on their own personal maladjustment, low tolerance for stress, or high standards for acceptability rather than on their child's actual behavior. We believe that traditional parent training programs incompletely serve families in group 2 by failing to address parental cognitive/psychological/marital/social maladjustment contributing to perceived or actual child deviance, and that traditional parent training for families in group 3 is completely inappropriate (p. 41).

Maintenance and Transfer of Training

The bulk of outcome studies on behavioral technology training projects have demonstrated short-term effects on consultee and client behavior. Some data are available to demonstrate the

continued use of specific behavioral techniques and the application of general techniques to new problems after the training program ends, although the percentage of cases in which this occurs is often quite low (Baker et al. 1980; Forehand and Atkeson 1977; Kazdin 1982b; McMahon et al. 1981). In one of the more promising studies, a 14-month followup of a parent training program for parents of retarded children, Baker et al. (1980) found evidence of continued use of specific strategies or techniques for about half of the trainees, and evidence of transfer of techniques to new problems for only 10 to 20 percent. Others have also found relatively limited transfer and maintenance effects of parent training (e.g., Johnson and Christensen 1975; Wahler 1980) and teacher training (e.g., Becker and Carnine 1980; Kazdin 1974).

The task, then, is to discover how to enhance the generalizability of training. Some evidence indicates the inclusion of formal training in general social learning principles is useful in this regard (McMahon et al. 1981), although instruction in general principles alone is generally not effective in producing even short-term behavioral changes (e.g., Gardner 1972; Kazdin 1974; Nay 1975). Continued contact with consultees after training, even if infrequent, also seems likely to increase maintenance and transfer (Baker et al. 1980). The real barriers to maintenance and transfer, however, probably lie in the ubiquitous system or setting characteristics (including personal characteristics of the actors in the system). Indeed, the lesson learned from parent training efforts appears to be that parent training alone, even if conducted over a relatively long period of time, is often not sufficient to bring about desired behavioral changes in either parent or child (Patterson et al. 1982). Effective intervention instead has directly addressed both parental resistance to the training and marital or individual problems occurring in the family (Patterson et al. 1982). This lesson seems likely to transfer to behavioral technology training efforts in other settings, such as with teachers in schools or staff in institutions.

Current Challenges

Behavioral consultation encompasses a wide variety of activities conducted in a broad range of settings with diverse populations. Its conceptual foundation is also quite broad, as behavioral technology principles have expanded to incorporate ecological and cognitive perspectives. Compared to other consultation models, behavioral consultation places by far the greatest emphasis on assessing effectiveness through systematic measurement. As a consequence, there is considerable evidence available to demonstrate the effectiveness (or ineffectiveness, as the case may be) of many behavioral consultation interventions. In spite of this

flexibility, a strong conceptual base, and rigorous methodology, several major challenges exist, many of which are variants of the issue of ecological validity. Included among these challenges are issues pertaining to the process of conducting behavioral consultation, the integrity of the intervention, the conditions that enhance acceptance of the intervention, the social identity of behavioral interventions, and the provision of ethical safeguards.

Conducting Behavioral Consultation

The task of actually bringing about meaningful and long-lasting changes in the behavior of individuals, groups, or organizations is difficult to accomplish in most cases, and there seems to be no substitute for an accurate understanding of personal and environmental characteristics when attempting to intervene. The field seems to be developing, albeit slowly, a solid knowledge base concerning the requirements for implementing and maintaining interventions (see, for example, Kazdin's [1982a] review of token economies or Griest and Well's [1983] review of behavioral training for parents). As a result of increasing experience with behavioral interventions in natural settings, terms such as "resistance" (e.g., Spinks and Birchler 1982) and "institutional constraints" (e.g., Reppucci and Saunders 1974) are beginning to appear in the behavioral literature. Unfortunately, the research base to guide the consultant in overcoming individual and environmental barriers is not well developed. This situation needs to be rectified in the future.

Integrity of Treatment

Many of the earlier descriptions of the application of behavioral technology principles to improve conditions in natural environments focused on how to reanalyze problematic situations from a behavioral perspective and to formulate prescriptions for change based on this analysis. It was assumed that (1) a proper analysis would result in the development of an effective plan and (2) the consultee would implement the plan as directed. The effectiveness of the plan would in turn reinforce the consultee's continued use of behavioral technology. Actually there is little evidence that this is the usual scenario in natural settings. All too frequently, the scenario becomes one of compromise regarding the strength and integrity of treatment, and various aspects of the intervention are not carried out as intended (Sechrest et al. 1979).

Kazdin (1982a) suggests that monitoring the integrity of treatment is essential to ensure that any program is being

implemented correctly. Yet process evaluation is a rarity as few settings have the financial and human resources (Reppucci and Saunders 1974) to ensure even what Kazdin (1982a) calls the "minimal condition" for integrity, i.e., "the continuous data collection on client or staff behavior" (p. 438). Developing ways to ensure the integrity of behavioral interventions is a major challenge that behavioral consultants must deal with in the future.

Appropriate Technology

A third challenge relates to identifying characteristics of programs that enhance their widespread adoption and result in institutional or programmatic change. Fawcett, Mathes, and Fletcher (1980) discuss the concept of an "appropriate technology" to increase acceptance of the intervention. Appropriate technology refers to procedures that are compatible with the ecological context, resources, philosophy, and values of the setting in which they will be used (Reppucci 1973; Reppucci and Saunders 1983).

Fawcett et al. (1980) and Kazdin (1982a) point out that ecologically appropriate interventions should be: "(a) effective, (b) relatively inexpensive, (c) decentralized and controlled by local participants, (d) flexible enough to permit local input, (e) sustainable with local rather than outside resources, (f) relatively simple and comprehensible, and (g) compatible with existing values, goals and perceived needs of the setting" (Kazdin 1982a, p. 440). For behavioral consultation to be successful in the long run, attention to these criteria is critical. Yet, with the exception of effectiveness in the short run, behavioral interventions have seldom been evaluated systematically in terms of meeting these criteria. Determining ways to evaluate and incorporate these criteria in light of other aspects of the ecology of natural environments represents a formidable challenge for the present generation of behavioral consultants.

Social Identity

The term "social identity" denotes a set of shared perceptions about the deviant or nondeviant status of certain people (e.g., the mentally ill) or of certain ideas, concepts, or theories (e.g., behavior modification) (Saunders and Reppucci 1978). For many individuals, behavioral interventions of any sort invoke negative visions of brainwashing, electroshock, institutional abuse, and visions of George Orwell's 1984 (1949). As a result, the term "behavior modification" and its derivatives including behavioral consultation often have a negative social identity (Saunders and

Reppucci 1978) among the public at large as well as among individuals and groups involved in the delivery or receipt of services. To pass this social identity off as trivial is to dismiss both the importance of labels (Becker 1963) and values. Several studies (e.g., Saunders 1975; Woolfolk et al. 1977) have demonstrated that the label "behavior modification" can adversely affect reaction to programs that are not evoked when the same program has a different label.

There is a palpable distrust and rejection of the mechanistic conception of human beings which behavioral interventions conjure up in the minds of many people. Although this reaction may be altered in the future, strongly held values and conceptions are slow to change even if they are unwarranted. Thus, behavioral consultants must be sensitive to the fact that in many settings they may be perceived negatively by at least some people before they even begin their consultation. The point is this: although most behavioral consultants are conceptually aware of many of the limitations of behavioral theory, there is a need for humility that has often been lacking in the past. This is not to suggest that there is not ample evidence for the effectiveness of behavioral technology in dealing with many human problems when it is used appropriately, but rather to suggest that social identity may be more of a determinant of people's perceptions than any facts regarding its effectiveness.

In addition, behavioral consultants must recognize that learning theory per se falls far short of having the knowledge base necessary to intervene successfully in many natural settings without using other explanatory concepts and being aware of ecological context and other systems issues that may pose barriers to appropriate implementation. If applied inappropriately, behavioral consultation will produce little desirable, lasting behavioral or system change, and can even be harmful. Horror stories abound of the blatant misuse of punishment contingencies under the label of therapeutic and scientific behavior modification. To guard against this, behavioral consultants must be armed with realistic knowledge of natural settings that will permit them to assess the usefulness and appropriateness of behavioral technology before initiating a consultation. In other words, there may be situations in which the likelihood of successful implementation of a behavioral program is too slim to begin the process and the consultation should be terminated early or never even begun.

Ethical Safeguards

Clearly related to the issue of social identity are the numerous ethical and value issues that surround the use of behavioral interventions. Although a thorough discussion of these issues is well beyond the scope of this chapter (see Brodsky 1980; Davison and Stuart 1975; Stolz et al. 1975), some mention is necessary because developing ethical safeguards for behavioral interventions may well be the major challenge of the next 15 years. Behavioral consultants should be in the forefront of this movement.

Skinner (1971) has stated that "[behavioral] technology is ethically neutral. It can be used by villain or saint. There is nothing in a methodology which determines the values governing its use" (p. 150). Although we agree, this disclaimer does not absolve behavioral consultants from the need to focus on these values. Rather it emphasizes the need for behavioral consultants to take the lead in developing safeguards that will increase the likelihood that behavioral approaches will be used to promote human welfare.

Heller and his colleagues (Heller et al. 1984) have suggested that behavioral consultation is a technology in need of values and goals. Especially in total institutions in which residents may be incarcerated against their will (e.g., prisons, mental hospitals, and retardation centers), behavior modification can serve to enhance individual competencies and treatment or can serve to control and punish. However, the question whether behavior modification is being used in the service of treatment or control is not ordinarily an easy one to answer. As one correctional psychologist put it:

These are double-edged swords which can be used as immensely helpful therapeutic adjuncts or as instruments of control and, yes, as abuses of power. In any situation where one group of humans has been provided with power over another, there is the spectre of abuse. The setup is an adversary one by definition, and the mental health expert inevitably gets caught in the crossfire. The most insidious concern with respect to behavior modification is the confounding of intentions--such as control vs. treatment (Clingempeel et al. 1980, p. 137).

It is this "confounding of intentions" phenomenon that requires behavioral consultants to be especially alert to the values and goals of the institutions with which they work. It also suggests that behavioral consultants should encourage the development and implementation of safeguards concurrently with any intervention program. Safeguards would include procedures to monitor treatment programs to ensure that participation is not

coercive, that consent is truly informed, and that the programs are humane and rehabilitative. Review committee of various types could perform these functions. For example, Heller et al. (1984) have suggested using committees composed of residents, staff, and public citizens, while others (e.g., Braukmann et al. 1975; Friedman 1975) have proposed the use of two levels of committees: a human rights review committee to examine the social and ethical implications of particular treatments and a peer review committee to look at the professional adequacies of the procedures.

While the welfare of residents within total institutions has most often been the focus of concern in discussing ethical safeguards for the use of behavioral approaches, it is important to note that value confounds may exist in other less coercive settings. For example, Winett and Winkler (1972) forcefully argued that developing behavioral techniques to reduce disruptive behavior in school classrooms in order to enhance learning may easily result in an emphasis on conformity and order that increases docility. In other words, behavioral interventions may become part of the problem rather than part of the solution (Holland 1978) unless behavior consultants actively engage in value clarification and encourage the development of safeguards concomitant with the development of the behavioral programs themselves. In most instances, safeguards have been left to others even when the potential for abuse has been recognized and articulated. This has usually meant few if any safeguards have been implemented. Accepting the responsibility for linking the development of behavioral programs and of safeguards would be a major progressive step. Finally, as an aside, we wish to stress that developing safeguards to protect individual liberties should be an integral part of all mental health and community consultation programs, not just those involving behavioral approaches.

Conclusion

Ten years ago, one of the authors of this paper and a colleague (Reppucci and Saunders 1974) concluded a paper entitled "Social Psychology of Behavior Modification: Problems of Implementation in Natural Settings" with the following paragraph:

Finally, there is an issue the resolution of which will have enormous consequences for behavior modification as we know and apply it today. The issue inheres in the fact that the principles of behavior modification are insufficient and often inappropriate for understanding natural settings--their structures, goals, traditions, and intersetting linkages

We are nowhere near a technological capacity or sophistication for Skinner's utopian notions, and Skinner's theory as currently elaborated is of demonstrated insufficiency to provide for that technology. This is simply recognizing that behavior modification was never intended to be a basis for describing, understanding, or changing natural settings. For example, there is nothing in behavior modification that guides us in answering these questions: Where should one seek to enter a setting? Where will the points of conflict arise? What will constitute a viable support system? What is a realistic time perspective for change? From one standpoint, these can be viewed as "practical" questions. From the standpoint of the organizational or systems theorist, these are questions that are basic in that how one answers them reflects the level of one's sophistication about complex social organizations. When behavior modification confronts its theoretical limitations, it will be on its way to a new stage of growth (pp. 659-660).

During the past decade, behavioral consultation has made many strides and has confronted many of its theoretical and conceptual limitations. Yet it still has a long way to go. The frontier remains vast, and as suggested by the previous discussion, many challenges still exist. The most important of these may be the active development of ethical safeguards to protect individual liberties.

In conclusion, behavioral consultation is a viable and powerful mode of intervention. There are signs of positive development in each of the three major consultative forms identified in this paper (behavioral case consultation, behavioral system consultation, and behavioral technology training), with increasing attention being paid to several important challenges. In many ways, the application of behavioral principles in the natural environment has become more refined and sophisticated, although clearly the more we learn about interventions in natural settings, the more we are aware of the gaps in our knowledge. To claim that behavioral consultation is a finished, well-tested product would still be unjustified in most instances. Nevertheless, the overwhelming evidence indicates its utility in many situations with many populations. We expect that the next decade will result in a consolidation of gains and lead to further refinement and sophistication in the theory and use of behavioral consultation.

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CHAPTER 4

ORGANIZATION DEVELOPMENT: AN APPROACH TO MENTAL HEALTH CONSULTATION

Christopher B. Keys, Ph.D.

The purpose of this chapter is to provide an integrative overview of the state of organization development as a form of mental health consultation. This overview includes a working definition of organization development (OD), basic assumptions, brief descriptions of major intervention strategies, and evidence concerning the impact of OD interventions.

Definition of Organization Development

In their comprehensive review of organization development in schools, Fullan, Miles, and Taylor (1980) defined organization development as:

a coherent, systematically-planned, sustained effort at system self-study and improvement, focusing explicitly on change in formal and informal procedures, processes, norms or structures, using behavioral science concepts. The goals of OD include improving both the quality of life of individuals as well as organizational functioning and performance (p. 135).

A number of important elements of OD are identified in this definition. First, OD is coherent and systematically planned. For these conditions to be met, the system needs to gather and organize information concerning the strengths and weaknesses of its past and current functioning. This information is organized according to an appropriate conceptual framework (cf. Weisbord 1978). The resulting assessment constitutes the first step of a self-study and may form the empirical basis for development of a plan for change.

Second, OD is sustained. Fullan, Miles, and Taylor (1980) offer the informal guideline of 18 months as a way to operationalize the term "sustained." The central issue is that organization development involves a series of related activities over a period of time. It is neither a one-shot site visit and report by a team of outside experts, nor is it a few self-improvement

workshops without an organizational assessment and a clear plan of action.

Third, system self-study and improvement is the heart of OD. A critical number of organization members, including key leaders, must be willing to examine the way the organization works and does not work. They need to be open to considering organizational improvements and investing considerable time and energy to implement improvements selected. OD is a relatively noncoercive strategy. While power dynamics, influence attempts, and persuasion may be secondary factors, fundamentally OD involves and motivates organization members to choose to make their workplace more productive and satisfying. System self-study and improvement are more likely to succeed if they are freely chosen (cf. Argyris 1970).

Fourth, OD is grounded in behavioral science. Historically, organization development is a descendent of Lewin's early action research and intervention in social psychology (Marrow 1977) and of Likert's survey research in organizational psychology (Cannell and Kahn 1984). Lewin's work spawned both laboratory training which emphasized interpersonal and small group issues, while Likert's survey research focused on more system-level concerns. Organization development includes both the more qualitative, small group tradition of clinical and applied social psychology and the more quantitative, system-survey tradition of organizational psychology and organizational behavior.

A key element in some other definitions of OD (cf. Schmuck 1976) is the role of the consultant. The OD consultant works with the system requesting self-study in a voluntary, collaborative, and explicitly structured relationship. There is a shared understanding about the purpose, methods, and intended outcomes of the OD consultation. Members of the system participate in defining organizational concerns and in implementing organizational change. Joint effort, not unilateral advice, is typical of OD consultation (Keys 1983).

The definition of OD has been a matter of great debate in the OD literature. A few would consider this definition of Fullan, Miles, and Taylor too narrow because it fails to indicate that OD can focus on the environment of the system and the system's technology, as well as on organizational processes and people. For example, Friedlander (1980) argues that OD must be multifaceted and that these facets may yield differential benefits. Thus, focusing on organizational processes and people may yield mental health benefits, but productivity effects are unlikely unless technology is also considered. Friedlander's arguments are thought-provoking and suggest new avenues for OD endeavors.

However, as a description of mainstream OD, the more focused definition of Fullan, Miles, and Taylor (1980) is preferred.

OD as Mental Health Consultation

Given these defining characteristics of organization development, in what sense may OD be considered mental health consultation? Organization development, with its emphasis on the organization as well as the individual, clearly differs from traditional mental health consultation with its individual focus. This difference may be a distinctive asset of OD. Gottlieb (1974) argues that early mental health consultation was limited in its impact, at times to the point of being self-defeating, because it did not address issues of organizational development and change. More positively, Goodstein (1972) indicates that successful mental health consulting about individual issues in organizations often leads to consulting on organizational concerns. Consequently, it may be useful to consider organization development as a constructive expansion of mental health consultation.

The editors of this handbook identify three defining characteristics of mental health consultation: (1) a three-party network, (2) a mental health goal, and (3) service. The goal of organization development to improve the quality of working life for individuals is similar to the goal of positive mental health. Since the clients involved in OD are likely to have fewer emotional problems than clients involved in psychotherapy, an emphasis on positive mental health is appropriate. Also, organization development consultation is a service and not primarily research or evaluation, although data collection is often part of the system's self-study.

The defining characteristic of a three-party network of consultant, consultee, and client is more problematic, however. In the organization development literature the distinction between the consultee who receives the consultant's services directly and the client who receives those services indirectly through the consultee is not made, at least not in those terms. OD consultants focus on clearly defining who the client is, which usually means whose needs and problems are given highest priority for the consultant to address. Thus, the OD literature speaks of the consultant and the client system with no mention of the consultee. Yet the norms and processes of OD consultation have much more in common with three-party mental health consultation than with two-party clinical consultation. As in three-party mental health consultation, the OD consultant with behavioral science expertise may train others to address problems (cf. Keys 1979). The OD consultant may work with members of the

system to enable them to use their ability and knowledge to resolve difficulties. The consultants may encourage the members of the system to generalize their new problem-solving approaches to new situations which they can work on independently (cf. Schmuck 1982). In fact, what happens in many successful OD consultations over time may be construed as the development of a consultee. That is, over time, the consultant works with the client system to develop internal resources for organizational self-study and improvement.

Kaplan's (1978) concepts and account of the development of a consulting relationship offer an apt prototype of consultee development (see figure 1). Kaplan argues that before organizational change can happen, a "metachange" must occur to bridge the distance between consultant and client. The metachange occurs in stages and may be considered consultee development. First, in the formative stage, the OD consultants are directive but judicious in introducing OD concepts and methods to organization members. Kaplan describes an OD consultation with a petrochemical plant to improve management-employee relations following a strike. The plant managers were confounded by the OD consultants who sought to collaborate rather than offer expert advice. After considerable testing during initial consulting activities, some organization members accepted the consultants. One member said he no longer saw them as "suitcase experts" (p. 53), but as people with something to offer. This acceptance signified the successful completion of the formative stage of a consulting relationship. During this formative stage, OD consultation involves a number of organization members including those who eventually will become full-fledged consultees. Often, the person who requested consultation initially will be a prime candidate to become the consultee or a member of a group of consultees. This formative stage can last anywhere from several months to 3 years depending on the readiness and internal talent of the organization, the effectiveness of the initial consultation activity, and the ability of the consultant.

The second stage of consultee development, Kaplan (1978) calls the normative stage. During this stage, some individuals in the organization come to believe strongly in OD principles and goals and start assuming responsibility for the OD project. During this stage the OD consultant seeks to encourage those in the organization to take initiative and to acquire needed internal resources. Emerging consultees may obtain additional training in behavioral science and OD. A manager at the petrochemical plant attended laboratory training to hone his interpersonal competencies for use in the OD project. In another consultation, several members of the internal change team in the Eugene, Ore., schools returned to the University of Oregon to do graduate study

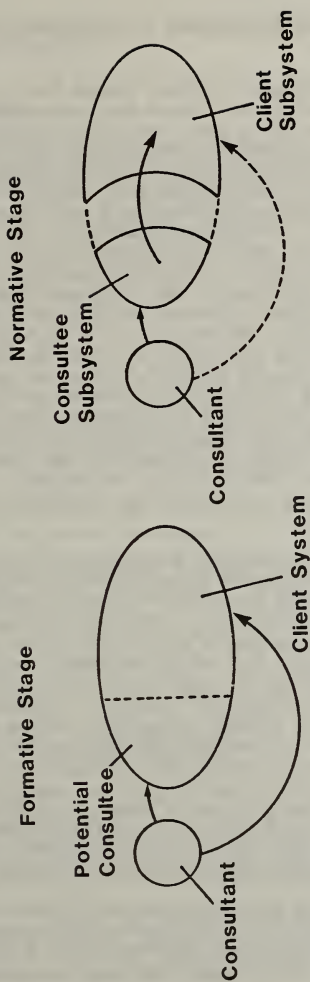


Figure 1. Consultee Development

about organization development in educational administration (Schmuck 1982).

As some organization members develop from clients to consultees, another constructive step is that the consultees prepare a statement of their beliefs, goals, intervention methods, and operating procedures. In both the petrochemical plant (Kaplan 1978) and the Eugene schools (Schmuck 1982), the consultees' preparation of a statement of purpose was a valuable step in articulating their working assumptions and developing psychological ownership of the OD efforts. Another characteristic of this stage is that emerging consultees begin working with the OD consultant or consulting team to assist in diagnosing, planning, implementing, and evaluating OD activities. This experience gives the consultees important insight concerning the cognitive and affective world of consultation and provides the consultants with more information about the organization and their relationship with it. One caution in consultee development concerns the confidentiality commitments the consultants make to staff members who provide sensitive information concerning the organization. The consultations must make those commitments so that they are ethically able to include consultees from the client system in their deliberations. They must also be vigilant in adhering to these confidentiality commitments as consultees become more involved.

The benefits of consultee development for OD are several. Clients may be more able to identify with one of their own rather than with an external consultant. Consultees typically know the system and its unwritten rules better than external consultants. Consultees can be the vehicle for multiplying the impact of the external consultants. They will be available to help the system continue its self-study and improvement over time without depending primarily on external resources. Consultees also can more readily monitor internal developments and help craft the OD intervention to fit the contours of the organization's unique social ecology. Given these benefits, it is not surprising that Fullan, Miles, and Taylor (1978) found that internal change agents such as principals were most effective in leading organization development efforts in schools. Ideally, this process of consultee development increases the number of internal personnel who can take constructive leadership roles in organizational change.

To return to the definitional question, it appears that in most instances OD begins with a two-party network of client and consultant. In many successful cases the client system differentiates over time into consultee and client subsystems. Consequently, the emergence of a three-party network of consultant,

consultee, and client may be one clear indication of successful organization development.

Major Directions

An organization development approach to mental health consultation can be considered to have two major directions: (1) improving organizational functioning in mental health and other human service agencies and (2) improving the mental health of individuals in their work settings. Improving the functioning of human service organizations is an important area that has received relatively little attention from OD consultants. Effective human services are the cornerstone of a humane society and are vital if basic human needs are to be met and human problems addressed (Goodstein 1972). Yet, according to the zeitgeist, these human services seem maligned or devalued relative to other segments of society (e.g., large corporations). Consequently, those who enter the human service professions with high ideals may find their idealism sorely tested by the very limited resources available to help them realize their goals. In fact, the combination of pressing client needs, idealism, and lack of support from society can place a considerable burden on the human services.

To cope with this burden, human service staff often use expressions like "we are for our clients" or, in an agency serving children, "what is important is the children." These are important statements of core values that focus and mobilize organizational effort. However, they are insufficient in and of themselves to establish and maintain healthy and rewarding organizational functioning. Human service personnel need to think about and work on systemic issues. Competence with control organizational processes (e.g., planning and solution implementation) and attention to staff concerns are necessary to organizational effectiveness. OD is clearly no panacea. However, it can increase an agency's organization competencies and help it develop, motivate, and deploy its human talent effectively.

The second major direction of OD is improving the mental health of individuals in the work setting. The importance of positive mental health for individuals is highlighted in definitions of organization development (Fullan et al. 1980; Huse 1975) and is important for the long-term effectiveness of organizational functioning. Draconian methods may employ threat or fear to create short-term productivity boosts. Extrinsic incentives also may motivate people to improve performance for a limited period of time. However, an OD perspective is idealistic and pragmatic

enough to argue for a mix of organizational support and accountability that will enable staff to sustain high levels of satisfaction and productivity. Thus, OD seeks to promote individual mental health because of the benefits for both the individual and the organization. On the other hand, in addition to encouraging positive mental health, OD practitioners may need to address the negative. Goodstein (1972) notes that on occasion OD consultants may be confronted with maladaptive individual behavior that has serious consequences for an organization, such as the unfounded, hostile accusations of a program head. In fact, he believes that it may be helpful for the OD consultant to have mental health competencies, such as an understanding of personality theory and psychopathology, to enable the consultant to deal constructively with maladaptive behavior.

Summary of Definition and Overview

In sum, OD is a form of mental health consultation that provides a service, has a mental health agenda, and may evolve into a three-party network of consultant, consultee, and client. OD emphasizes both organizational and individual concerns. When OD procedures are used simply for organizational purposes (e.g., maximizing profits or increasing caseloads), one can question whether such consultation is in fact OD, since no mental health purpose is being served. Similarly, training activities that serve essentially individual purposes (e.g., relaxation training or assertiveness training) without addressing organizational concerns are not organization development. Next, the conceptual underpinnings of OD are examined.

Basic Assumptions and Key Concepts of Organization Development

Given the above overview, five basic assumptions and concepts of OD consultation emerge and are discussed in this section. They are as follows:

1. Supporting individual growth and development,
2. Believing in the efficacy of collaboration and openness,
3. Seeing effective organizations as self-renewing systems,
4. Appreciating the complexity and uniqueness of organizations and individuals, and

5. Working with the dialectics of organizational functioning.

Individual Growth and Development

One basic assumption of the organization development approach to mental health consultation is that people seek to grow and develop, especially after their basic physical and psychological needs are met (Huse 1978; NTL Institute 1970). This assumption is drawn from person-centered theories of personality (Maslow 1970; Rogers 1959) which espouse a positive view of individuals and their capacities. This assumption reflects the fact that an OD consultant typically works with people who do not have severe emotional problems. It also underscores the emphasis of OD on promoting positive mental health. This assumption prompts the OD consultant to look for ways to reduce organizational hindrances to individual growth and to seek ways to promote the positive mental health of staff. For example, the development of consultees as described above provides an opportunity for individual growth, as well as organizational improvement.

Clearly, if people seek to grow and develop, jobs should be structured to address these needs. This positive approach to individuals is reinforced by Peters in his work concerning organizational excellence (Peters and Waterman 1982). He maintains that one of the three critical characteristics of excellent corporations is a "bone-deep" belief in the potential ability and integrity of all their personnel (Brenner 1984). Furthermore, in a democratic society that has met the basic needs of many citizens, this belief in individual growth and development implies that growth on the job should be an option for as many workers as possible.

Collaboration and Openness

The second assumption of organization development consultation is the efficacy of collaboration and openness. That is, when the norm of collaboration between organization members is stronger than the norms of competition or individualism, other things being equal, the organization is more effective. Bartunek and Keys (1979) reviewed the literature on participation in decisionmaking and concluded that appropriate collaboration by relevant people in making important decisions could be a means for improving both the quality of solutions and commitment to their implementation. Similarly, when the norm of open, direct communication between organization members is stronger than the norms of closed or indirect communication, the organization is

more effective. For example, Huse (1978) argues that being open to confront differences can generate new facts and options that may effect individual and organizational improvement. A corollary of this assumption is that collaboration and openness, other things being equal, also lead to job satisfaction and psychological well-being.

This belief in the efficacy of collaboration and openness is evident in OD consultation. The consultation seeks to develop an open, collaborative relationship with members of the client organization. The methods of OD typically involve more public sharing of ideas, feelings, and beliefs about the organization and its strengths and weaknesses than had been occurring prior to the consultation. OD consultations usually intervene to try to reduce counterproductive competition and increase collaboration between individuals, cliques, and subsystems. As Kegan and Rubenstein (1973) demonstrated, such OD interventions may increase trust among co-workers--and greater trust may yield mental health benefits.

Finally, one implication of greater collaboration and openness between superiors and subordinates is that the superiors share more information and thus may change their power relationships with subordinates. For example, Bartunek and Keys (1982) found that, compared to school principals whose schools did not participate in OD consultation, OD principals had direct and indirect relationships of influence with more teachers, but were less central or tightly linked to them. Thus, more collaboration and openness may mean more connections but fewer hierarchical prerogatives for leaders.

Organizational Renewal

A third assumption of an organization development approach is that effective organizations are self-renewing rather than self-perpetuating or self-destructive. Self-renewing organizations are adept at sensing the external and internal environments of the organization and finding pertinent issues and problems. They are effective in gathering information relevant to those problems and using it, and they show imagination in creating plans to address those problems. They can take action to implement their plans and to evaluate the effectiveness of their problem-solving efforts.

They can manage the socioemotional issues that parallel these task processes in problem solving. That is, self-renewing organizations are competent in including and involving relevant organizational members (cf. Bartunek and Keys 1979) and in

focusing and summarizing organizational discussion. They are able to cope constructively with conflict, to adapt to unanticipated circumstances, and to mobilize energy for followup activity. In short, the effective organization is skillful in the task and socioemotional competencies of organizational problem solving (see figure 2). For the OD consultant this renewal assumption reflects what Friedlander (1980) calls a "meta-purpose of OD," that is, developing the organization's own capacity to identify and solve its current and future problems.

| <u>Task Dynamic</u> | <u>Socioemotional Dynamic</u> |
|--|---|
| Sensing the internal and external environment and finding problems | Including and involving relevant organizational members |
| Gathering and interpreting information | Focusing and summarizing organizational discussion |
| Creating plans | Coping constructively with conflict |
| Implementing plans and problem solutions | Adapting to unanticipated circumstances |
| Evaluating the effectiveness of solutions | Mobilizing energy for followthrough activity |

Figure 2. The Dynamics of Organizational Renewal

These first three assumptions--an individual's tendency for growth, the efficacy of collaboration and openness, and organizations as self-renewing systems--are longstanding articles of faith in organization development. The next two assumptions are more recent additions that have evolved from developments in organizational theory and OD practice during the last decade.

Appreciation of Complexity and Uniqueness

The fourth major assumption of OD consultation is that organizations and individuals and their relations with one another are complex and unique. Sampson (1977) has noted the strong tendency to overattribute behavior to individual causes. Keys (1983) has emphasized the need to think organizationally to identify factors influencing individuals' behavior on the job. Organizational history, norms, and incentives may be as important as an individual's learning history, ego strength, or interpersonal style in accounting for workplace behavior. Organizations have informal goals, structures, and processes that parallel, influence, and often dominate their formal counterparts. Recently, organizational theorists have called particular attention to the importance of the organizational culture, that informal matrix of interactions that constitutes a significant part of organizational behavior (cf. Deal and Kennedy 1982; Schein 1983). Weick (1976) and March and Olsen (1976) focus on the loosely coupled, irrational processes that play a significant part in organizational functioning.

Kouzes and Mico (1979) describe the unusual complexity found in mental health and human service settings. They note that in these settings there are often as many as three domains, each with its own goals, formal processes, and culture. The policy domain addresses important nonroutine issues concerning the organization's relationship to important external systems. The bureaucratic domain deals with routine internal matters of personnel and paperwork, and the professional domain provides services to clients. One of the organizational challenges of human service agencies is managing the relations among those three domains. In short, it is simpleminded to attribute behavior solely to style, personality, or other individual characteristics. Complex organizational factors also need to be considered.

What are the implications of this complexity assumption for the OD consultant? First, OD consultants need to realize that many factors affect individual and organizational functioning in addition to those identified in the first three assumptions stated above. Organizations are usually richer, more diverse settings than theories indicate. Individuals battle with and can be limited by past problems. They are not always motivated by desire for growth and development. Collaboration and openness are usually efficacious, but competition and secrecy have their place in organizational behavior. Organizations can work many ways and provide service in a creditable fashion without being optimally self-renewing.

Second, given the complexity of organizational and individual functioning, OD consultants need to do careful organizational

diagnoses in order to understand the characteristics, language, goals, and norms of a particular system (cf. Weisbord 1978). Each organization has a distinctive culture, unique solutions to the common challenge of achieving together. General organizational principles can apply to a particular setting. However, without substantial, high-quality information about the particular setting, the consultant will be unable to apply those principles effectively. Consequently, organizational diagnosis enables the OD consultant to identify key issues and develop intervention plans to address those issues that are tailored to a particular organization's leadership and culture.

Finally, OD consultants need to gather information in a broad-gauged, systematic way about the impact of their work more frequently. Complexity increases the likelihood of differential impact across subsystems and individuals. Unfortunately, careful, thorough evaluation has been the exception, not the rule, to date for consultation in general, and OD consultation in particular (cf. Porras and Berg 1978a). Consequently, our understanding of the complex contingencies that affect the implementation and outcome of OD is based too much on anecdote and not enough on high-quality, empirical research.

Recognition of the Dialectics

The fifth assumption of OD consultation is that there are important dialectical processes that operate during consultation. Dialectical processes refer to interrelated forces that can sometimes operate in opposition to one another and at other times can complement one another. Two common dialectics are the individual-organization dialectic and the task-socioemotional dialectic. The individual-organization dialectic concerns the relation between individuals and the organization. Organization development can be a way to confront the tension between individual autonomy and organizational control. OD consultation can also reflect this dialectic. As a consultative approach OD has consistently endorsed democratic values affirming the importance of the individual. Yet, the OD literature generally (but not always, cf. Porras and Berg 1978b) holds that organizational backing from the top of the hierarchy is essential for successful consultation. One clear challenge for OD consultants is how to work constructively with both individual and organizational perspectives.

Similarly, the task-socioemotional dialectic is important in many consultations. Client organizations usually give misplaced emphasis to either the task or the socioemotional dimension of their work (typically the task side, but not always, especially in

the human services). One aspect of the consultant's role is to introduce and focus the client's attention on the neglected dimension, so that the problems in that sphere come to light and receive attention. However, clients may tend to stay in an area with which they are comfortable. The OD consultant needs to acknowledge client's strengths in, for example, the task area and note the importance of that area. Then the consultant can help the client look at both the task and socioemotional dimensions and develop a more workable balance between them.

In sum, OD consultants understand the dialectics of organizational processes and therefore are able to perceive the larger picture. Thus, they can be more flexible in working with these dialectics and more appreciative of the many elements involved in effective change. In my experience, the best consultants are always seeking and finding new insights about how organizations work, how leaders use power, and how consultants can be more effective. Developing a more articulated, cognitive map of OD consultation is an ongoing task for the serious consultant and is an important benefit of working with the dialectics.

Now that the definition and basic assumptions of OD have been identified, a typology of intervention strategies will be presented.

Intervention Strategies of Organization Development

The complexity of organizational consultation has engendered a diverse range of OD interventions. These interventions are a central aspect of the consultation cycle of entry, diagnosis, implementation, evaluation, and future planning. Typically, sub-stained OD consultations move through this cycle several times, include a number of different interventions, and in some way become an ongoing part of the organization. These interventions can vary as a function of (1) the issues that are paramount, (2) the unit that is the focus, and (3) the depth that is needed to address the issues effectively (cf. Blake and Mouton 1976; Schmuck and Miles 1971).

Paramount Issues

The issues that are the focus of organization development usually concern organizational processes that are crucial to organizational effectiveness and individual well-being in the workplace. These may include clarifying communication, establishing shared goals, working with conflicts, understanding the leader and the leader's impact, interacting effectively in groups,

solving problems, and assessing changes (Schmuck 1979). In each organization these general issues have their distinctive focus and unique connections to other concerns.

In addition, certain issues often take priority and need to be addressed before other issues can be productively considered. For example, a growing community mental health agency was beset with problems of low morale, an uncommitted board, and ineffective staff meetings. However, before constructive action could be taken on these issues, the style of the director and her impact on the middle managers and treatment staff needed to be discussed. An agency retreat gave the staff the opportunity to give the director feedback, and subsequently the director changed some of her behaviors to give the staff more overt support. During further consultation, the staff members were then able to more effectively develop and implement plans for agency problem solving (cf. London 1984).

To date, little research has been reported that specifies a particular sequencing of issues in consultation that has the greatest likelihood of success. However, one initial sequence that is consistent with several sources (cf. Colarelli, personal communication, June 1970; Goodstein and Boyer 1972; Schmuck 1976; Sorenson and Keys 1983) is this:

1. First, look for potentially debilitating problems such as significant concerns about leadership or serious conflict between important members of the organization.
2. If such problems exist and are consuming substantial energy, then focus on them. If the client has sufficient strength, resilience, energy, and commitment to tackle these problems openly, then proceed to make them an initial focus of the OD intervention. If not, then reconsider the usefulness of the consultation. Remember that a procedure rooted in democratic participatory values can only work if a critical mass of potential participants want it to work.
3. If potentially debilitating problems do not exist, then consider the skill levels of the client in areas like communication and problem solving.
4. If the skill levels are lower than necessary to support effective collaboration, then focus on skill training.
5. If the skill levels are acceptable, then use those skills to focus on improving important organizational

processes like goal setting, group meeting procedures, and assessment of change.

Basically, this sequence recommends moving from dealing with serious socioemotional problems to building competencies to improving task functioning. One assumption is that serious socioemotional problems are likely to undermine efforts to improve competence building and task functioning (cf. Goodstein and Boyer 1972). A second is that competencies in communication and problem solving increase the likelihood of success in improving organizational functioning (Schmuck 1976).

Unit of Focus

In addition to the paramount issue, the unit of focus is a factor in determining the type of intervention to be used in an organization development consultation. The unit of focus for an intervention may be the individual, role, dyad or trio, group, related groups, organization, or larger system that participates in the intervention and is the primary target of intervention activities. Interventions vary widely in unit of focus--from teaching a single school principal a seven-step planning procedure (Maher 1983) to providing cultural awareness training for white police cadets and black residents who represent an entire community (Reddy and Lansky 1975).

Interventions focusing directly on enhancing organizational processes should include those who have expertise in the processes, knowledge of the current situation, and responsibility for implementation. Thus, all shifts of direct care staff and supervisors of a group home are invited to discuss ways to improve their staff meetings. Also, as consultees develop within the client system, they may participate in intervention activities.

Typically several different units will be involved in different interventions during the course of a consultation. The initial data gathering and feedback may involve a large organizational unit in order to obtain multiple perspectives and to heighten awareness of the OD consultation. Subsequent interventions that address potentially debilitating problems usually focus on only those who are protagonists for a particular problem. Thus, a conflict resolution intervention with top and middle management in a large State facility for the retarded included only six managers who were centrally involved (Sorenson and Keys 1983).

Depth of Intervention

The third major factor in determining the type of intervention in OD is depth. Depth refers to how personal, hidden, and central to the individual's core of personality are the concerns and processes of the intervention (Harrison 1970). Behavioral science interventions may vary from those that are concerned solely with public, organizational processes, e.g., operations research, to those that focus primarily on private, personal concerns, e.g., task group therapy (cf. Diamond 1984). Organization development interventions are typically of intermediate depth since they focus on both individual and organizational concerns that are usually neither as personal as psychotherapy nor as public as operations research. The OD interventions with less depth tend to use more impersonal processes (e.g., the questionnaires of data feedback) and focus on organizational task concerns (e.g., problem solving to increase the pool of qualified job applicants). These interventions are concerned more with role behavior and other instrumental matters. On the other hand, OD interventions with more depth tend to use group and interpersonal processes (e.g., small group feedback in conflict resolution) and focus on socioemotional concerns (e.g., promoting participation in staff meetings).

Harrison (1970) indicates that greater depth of intervention requires greater interpersonal competence by the consultant and involves greater risk of difficulty. He prudently recommends that the least deep intervention necessary to address the issue effectively is the most preferable. He also notes that deeper interventions may be more at variance with the norms and culture of an organization than less deep interventions. This cultural gap can make it difficult to incorporate progress made in an intervention into the daily routine of life in the organization. It can also make the development of consultees slower and more problematic. Consequently, Harrison also recommends intervening at a level no deeper than that which mobilizes the energy and commitment of the client system for organizational improvement. Harrison's recommendations seem generally sound, not only for business settings (cf. Kaplan 1978) in which interpersonal topics are rarely discussed, but also for human service settings where interpersonal issues may be more openly considered but still very sensitive.

In short, the what (the issue), the who (unit of focus), and the how (depth) of OD interventions vary widely to determine the specifics of consultative activity. These three factors may be taken together to define a three-dimensional typology for OD intervention, as indicated in figure 3 (also cf. Schmuck and Miles 1971; Blake and Mouton 1976).

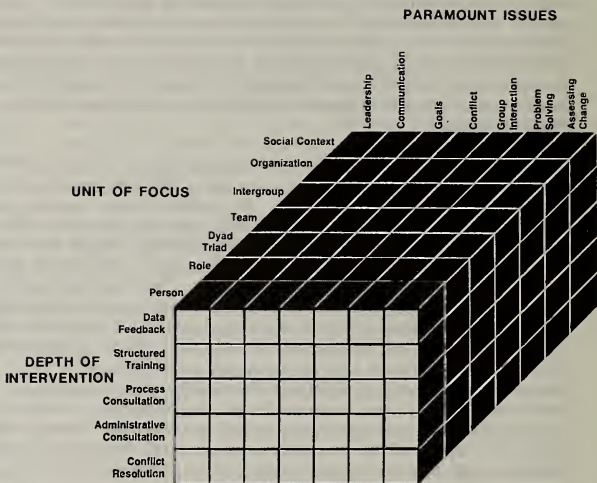


Figure 3. Typology for OD Interventions

Primary OD Interventions

While there are innumerable intervention activities (cf. Pfeiffer and Jones 1980), the primary types of OD intervention are: (1) data feedback, (2) group training, (3) process observation, (4) conflict resolution, and (5) administrative consultation. Each is briefly introduced here.

Data feedback. This involves gathering information concerning organizational issues of the client system, analyzing and interpreting the information, and presenting it to the client for discussion and planning (Francisco 1979). Data feedback may seek to examine particular issues of concern to the organization (e.g., how to improve communication between two agency programs), to provide a broad-gauged appraisal of organizational strengths and weaknesses, or to consider a mix of particular and general concerns. The data are provided primarily by members of the client system and occasionally by others who are actively involved with it. Typically survey questionnaires and sometimes interviews are used to gather information. Data feedback is usually no deeper than the instrumental level of depth because both the content and process focus on organizational issues and roles, not on individuals or interpersonal relations.

Data feedback is a valuable strategy for assembling useful information about organizational concerns from many people from different roles and levels in the organization. Consequently, it reduces pluralistic ignorance and establishes a baseline against which to measure improvement. It can reduce cognitive processing errors (such as overemphasizing an infrequent incident that affected only a few people) by separating information from affect. This emphasis on information can enable people to see the big picture and key issues without being sidetracked by local turf and power concerns. On the negative side, data feedback can be cumbersome because of the large amounts of information that are often collected and need to be quickly and succinctly distilled (cf. Keys and Wener 1980). Also, the most commonly used method of data collection, the questionnaire, lacks the rapport-building properties of other methods such as interviewing. Nonetheless, data feedback can be an excellent way to establish an agenda for an OD consultation that is tailored to the needs of a large client system (cf. Block, 1981).

Group training. In group training, the OD consultant presents new information, attitudes, and skills to members of the client system. The training usually occurs in small groups of 30 or fewer and employs participatory methods such as group discussion, structured activities, and role plays. The training topics typically concern the improvement of organizational processes or individual

well-being, such as coping with stress, time management, communication skills, and collaborative problem solving. Group training may include intact work groups, all those in a particular role, or a cross section of interested volunteers. Group training typically focuses on role-related concerns, but the methods used are participatory and may vary from structured and instrumental in task-focused training to unstructured and interpersonal in process-focused laboratory training. Consequently, it is generally a deeper intervention than data feedback.

Group training can be a useful way to promote the development of positive norms that are consistent with OD assumptions and values. It can enhance interpersonal and organizational competencies, accelerate the development of working relations, and build group cohesion. The personal contact between the consultant and client can strengthen that relationship. On the negative side, group training can miss the mark if it is not focused on the needs of the client system, a particular danger with pre-packaged training programs. To be effective, it should be time-consuming (e.g., more than 5 days [Bell 1977; Porras and Berg 1978b]), but such an intensive experience may create divisions between those who participate and those who do not.

In sum, group training is the core element of many OD interventions because of its participatory quality and the opportunity it offers to present OD ideas, skills, and attitudes. However, for maximum impact, group training needs followup to encourage application at the work site. Process observation is one means of followup.

Process observation. In process observation, the OD consultant watches group or team activity, provides feedback to the group, and facilitates discussion of the group's functioning. Usually an intact work group or task force is observed at work (cf. Schein 1969). The observation may emphasize group, role, interpersonal, or individual matters, although usually role and group are most central. Process observation can be a useful vehicle for reflecting on the strengths and weaknesses of a group's meeting and general functioning. It can be an opportunity for the consultant to coach the group on effective working procedures. Most important, over time it provides support to a work group, as it seeks to improve its effectiveness. As part of a larger consultation, process observation may give the consultant one indication of the impact of prior data feedback and training interventions on life in the workplace.

On the negative side, process observation makes demands on work time usually devoted to other activities. It will not work if the consultant lacks the skills of observation or giving

constructive feedback. Most important, as usual, is the commitment of staff, particularly the leader, to the process of being observed by an outsider, taking negative feedback nondefensively, and openly discussing their ways of working together. Given both its emphasis on instrumental issues with some attention to interpersonal ones and the sensitive interpersonal processes involved in providing immediate feedback, process observation generally involves more depth than data feedback and is usually as deep or deeper than group training.

Conflict resolution. This is yet a deeper organization development intervention. It refers to bringing together two parties (individuals or groups) that have important differences due to miscommunication, value differences, external pressures, or other causes. The purpose of conflict resolution is for each party to articulate, understand, and if possible resolve their differences. Typically the parties involved are interdependent, and the conflict has begun to interfere with their capacity to work together. Blake, Mouton, and Sloma's (1965) intergroup imaging is one of the best-known and most useful procedures for surfacing and resolving conflicts.

Conflict resolution is a high-risk, high-gain proposition; outcomes are rarely neutral. Because of the affect that has accumulated around the issues and people involved, usually interpersonal concerns and at times personal ones are salient. Consequently, the OD consultant should approach conflict resolution with great care, to be sure that both parties feel the consultant understands their position and is unbiased before bringing the antagonists together. Private interviewing with the antagonists is a valuable way for the consultant to learn about their issues, attitudes, intensity of affect, and willingness to work on resolving the differences. With solid preparation and a willingness to resolve differences on the part of both parties, some real breakthroughs are possible. Without preparation and commitment, real breakdowns are more likely. Consequently, use of conflict resolution is advisable only when the consultant perceives a reasonable likelihood of success.

Administrative consultation. This has the most variable goals and depth of these five intervention strategies. Administrative consultation refers to meetings between the OD consultant and the client organization's leader or leaders, as part of a larger consultation. While these meetings may have multiple objectives, they serve the overall goal of the OD consultation. More specifically, these meetings may include: (1) obtaining background information from the top managers, (2) planning and negotiating subsequent steps in the OD consultation, (3) giving the top managers sensitive feedback about leadership style and organizational

functioning, (4) coaching the top managers on ways to handle difficult situations (e.g., confrontation meetings or personnel changes), and (5) receiving feedback from the top managers about the consultation. Given these diverse objectives, administrative consultation can vary in depth from the instrumental elements of system assessment and planning to interpersonal and even intrapersonal issues of the top manager's behaviors, attitudes, and feelings and their impact. Over time the depth of administrative consultation may move through a cycle from instrumental to interpersonal and possibly to intrapersonal and then back again to instrumental.

Administrative consultation often happens informally as part of the debriefing following group training or other intervention activities. It is an important means of building rapport with the leadership of the client system. It provides a means of reality testing for the consultant that increases the likelihood that an intervention will be responsive to the needs, strengths, and limits of the client. It can strengthen the top manager's competence and resolve to deal with the demands of the job. It can develop the commitment of top management to follow through in the consultant's absence.

One potentially negative side effect of administrative consultation is that the OD consultant may be seen as an ally of top management. Therefore, it is important that the consultants also spend time with a cross section of the organization and seek out multiple perspectives.

In closing this brief description of several leading intervention strategies in OD, we may see how they can complement one another. Data feedback first provides an overview and working understanding; training delivers new ideas, insights, and skills; and process observation facilitates their application at work. Conflict resolution helps untangle the tensions, and administrative consultation threads throughout to provide informed leadership that holds the consultation together. At the close, data feedback documents the record of accomplishment.

The Impact of OD

In its first 30 years organization development has been conducted in a wide variety of organizations. From its beginnings in the military and in business and industry, it has spread to schools (cf. Schmuck and Miles 1971; Fullan et al. 1980), mental health settings (Glaser 1977; Walsh et al. 1974), government agencies (Goodstein and Boyer 1972; Paul and Gross 1981), criminal justice organizations (Keys et al. 1978), churches (Anderson and Lake

1972; Mead 1978), health care systems (Cherniss 1984), facilities for the developmentally disabled (Spry 1978), and institutions of higher education (Bolton and Boyer 1973).

In general, frequency of use of OD has not been well documented in these various kinds of organizations. However, Fullan, Miles, and Taylor (1978) obtained reports of 75 OD projects in schools from a large-scale survey. They estimate that OD consultation has been conducted in approximately 1 percent of the school districts in North America. Given the relative frequency of published reports, it is likely that of the types of organizations mentioned above, only large, for-profit corporations have as high or higher percentage of use. This rate of use constitutes neither a tidal wave nor a drop in the ocean of change, but it indicates that OD is an approach of some interest.

What have we learned from the published evaluations of OD about its success, the effectiveness of different intervention strategies, and the conditions for successful OD? Fullan, Miles, and Taylor (1980) reviewed 14 reviews of OD research in general, as well as the leading evaluations of OD in schools. Across reviews, the rate of success of OD consultation, however defined, varied from 44 percent (Franklin 1976) to 87 percent (Dunn and Swierczek 1977), with many falling in the range of 50 percent to 67 percent. Fullan, Miles, and Taylor's own review of OD research in schools yielded a success rate of about 50 percent.

However, these success rates are at best difficult to interpret. In some cases success is defined by assessments on 16 dimensions of organizational functioning (Franklin 1976) and in others by the opinion of a sponsor and an appraisal of degree of adoption on a four-point scale (Dunn and Swierczek 1977). Not only does the definition of success vary greatly, but so does the quality of the consultation. Fullan, Miles, and Taylor (1980) note that many activities labeled OD consultation are at best pale shadows of the real thing. They lack a coherent conceptual framework, focus solely on the individual, examine unimportant issues, and fail to tailor interventions to the setting and its particular problems. Consequently, the reported frequency of success may suffer due to the inclusion of these weak attempts. On the other hand, given the bias of authors and journal editors to publish success stories, the rate of success among published sources may overstate the rate for all OD consultations.

Another salient factor affecting the reported success rate is the quality of the evaluations themselves. Fullan, Miles, and Taylor (1980) complain that too many studies rely solely on questionnaire data, lack appropriate control groups, do not include longitudinal data beyond pre- and post-measures, and have

measurement errors and artifacts. Also, many evaluations appear to be performed by the same OD professionals who conducted the consultation. Thus, while the methodological shortcomings may hamper detection of the effects of OD, the lack of independent evaluators may limit the credence given to those effects that are detected.

More positively, both Fullan, Miles, and Taylor (1980) and Porras and Berg (1978a) report improvement in the rigor of OD research. Porras and Berg (1978a) found 35 studies that assessed actual organizations or subsystems using quantitative procedures to measure relevant systemic processes. Over 70 percent used quasi-experimental designs, 49 percent had comparison groups, and 52 percent had more than 50 subjects. While OD research is improving, the comprehensive, multi-state, multi-method longitudinal nature of high-quality efforts means that knowledge about OD effectiveness will accumulate gradually.

In terms of more specific effects, Porras and Berg's (1978b) analysis of their sample of 35 studies yields some interesting findings. First, there is evidence for the positive impact of OD for individual mental health broadly defined. Porras and Berg (1978b) reported that individual process variables (e.g., self-awareness, openness, self-development, and actualization) showed improvement in 62 percent of the studies in which they were assessed. Also, individual satisfaction of all types improved in 38 percent of the studies, and satisfaction with the more enduring aspects of work (e.g., the organization, pay, security) increased in two-thirds of the investigations. Second, group and organizational outcomes and processes also showed improvement ranging from a high of 63 percent for group outcomes (e.g., quality of meetings, group performance) to a low of 36 percent for organizational process (e.g., norms, influence). On balance, it appears that OD may affect individual, group, and organizational levels, but that it has been somewhat more effective in demonstrating impact at the individual level.

Third, in addition to the individual-organizational dialectic, there was evidence that across studies, OD has an impact on both ends of other dialectics as well. Outcome variables improved in 51 percent of the instances reported and process variables 46 percent. Task variables changed positively 45 percent of the time and people-oriented variables, 46 percent. Thus, while the emphasis and reputation of OD is on processes and people, it has affected outcomes and tasks nearly as often. Thus Porras and Berg's (1978b) review offers support, albeit preliminary, both for the mental health benefits of OD for individuals and for OD as a way of improving both sides of dialectics central to group and organizational functioning.

Comparative research has begun on a small scale. Dunn and Swiercek (1977) used retrospective case analyses to compare participative management, organization development, socio-organizational design, and institution building. They found distinctly higher rates of success (as defined above) for the participatory approaches of organization development and participatory decisionmaking. Bowers (1973) compared data feedback, interpersonal process consultation, task process consultation, T-groups, data handback, and no-treatment conditions in 23 organizations. Bowers found that of the various conditions, data feedback (or survey feedback) had the most positive impact on 16 indices of organizational climate (e.g., support, influence, and satisfaction). This finding may in part be due to the high-quality model of data feedback consistently used by Bowers and his colleagues. Porras (1979) classified 35 studies according to their dominant intervention--that is, task-oriented training, process-oriented training, eclectic survey feedback, or managerial grid. Task-oriented laboratory training was significantly more effective in leading to positive group processes than were the other methods. Both Bowers and Porras and Berg reported that process-oriented laboratory training or T-groups by themselves were not particularly useful. Porras and Berg (1978b) found that if more intervention approaches were used (especially if four or more intervention types were used), the impact was greater. These initial comparative investigations break new ground in providing empirical evidence concerning the strengths and weaknesses of different intervention strategies. However, to date, the data are too limited, the numbers too small, and the generalizability too uncertain to expect firm conclusions.

Franklin (1976) examined conditions that differentiated successful and unsuccessful OD consultation. He found that successful OD occurred in organizations that were involved and receptive to change and adaptation rather than in those that were stable and committed to the status quo. Careful selection of internal change agents with skills in diagnosis and intervention planning also characterized successful OD projects. Fullan, Miles, and Taylor (1980) note that effective OD is systemic, carefully planned, and has the ongoing support of top management. It focuses on specific problems, not general ones, and on structural organizational change rather than solely on personnel concerns. Effective OD consultations usually have a part-time project manager and competent external consultants, and develop well-trained internal consultants. Interestingly, they report that moderate costs (e.g., \$10,000 annual costs in 1977 dollars) were associated with successful school OD projects. Too little funding yielded too little activity. Too much funding signified external grant support that school systems were unable to maintain following the end of the grant.

Summary and Future Directions

Organization development with its humane values and participatory methods may be considered an approach to mental health consultation that addresses both organizational and individual concerns. Defining characteristics of organization development are that it is coherent, systematic, and sustained, and involves system self-study and improvement. Also, it is grounded in behavioral science and involves a freely chosen, mutual consultative relationship. To reiterate, the basic assumptions of organization development are:

1. to support the individual's tendency toward growth, development, and positive mental health,
2. to value the efficacy of collaboration and openness,
3. to view effective organizations as self-renewing systems,
4. to appreciate the complexity and uniqueness of individuals and organizations, and
5. to work with the dialectics of organizational functioning.

Intervention strategies in organization development vary as a function of the paramount issues, the organizational unit involved, and the depth of intervention needed. While there are many specific intervention activities, the primary types of OD intervention are data feedback, group training, process observation, conflict resolution, and administrative consultation. Complex OD consultations may include several of these types of interventions.

Preliminary research findings concerning OD provide grounds for guarded optimism. On the positive side, the OD research literature is becoming more rigorous and has reported a number of successful examples of OD. OD has had a positive effect both on individual mental health and on organizational processes and outcomes. Comparative research seems to favor data feedback, task group training, and combinations of intervention types. On the other hand, OD studies still suffer from measurement problems, and the massive scope of comprehensive OD research means knowledge accumulates slowly.

On the whole, the emergence of OD as a form of mental health consultation provides a helpful approach for mental health professionals to use in addressing organizational concerns in

human service systems and individual mental health concerns in the workplace. In the next decade, OD consultation is likely to continue to be used in an ever-increasing number and variety of organizations to address organizational and individual concerns. In some important ways OD practice is changing. Practitioners are becoming more aware of the role and importance of power in organizational life. They are more interested in effecting structural and technological change and improvements in productivity. The content addressed by OD is now more likely to be retrenchment, fund raising, and computerization rather than integration, individualized curriculums, or police-community relations. New applications of OD involve establishing resource exchange networks among individuals and organizations and enhancing the ability of middle managers to cope with change.

However, in some fundamental ways, OD remains the same. Finding effective, voluntary ways to work together with other human beings to accomplish positive organizational and individual goals remains the core. Whether the current buzzword is excellent, Japanese management, or participatory democracy, the definition, the basic values, and the concepts endure.

As Rand (1978) has noted, the values and goals of OD and mental health are quite similar. Both "seek to treat problems between people, halt the processes which cause their recurrence, prevent the emergence of new difficulties, and promote positive mental health in people" (p. 165). Mental health professionals are now focusing more on the importance of a psychologically healthy work environment for overall individual well-being (cf. Price 1984). Organization development can be a constructive, systemic way for mental health consultants to reduce and prevent mental health problems in the workplace.

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PART III

MENTAL HEALTH CONSULTANTS

CHAPTER 5

THE PSYCHIATRIST'S ROLES AND FUNCTIONS IN THE 1980s

John J. Schwab, M.D.

Introduction

During the last few years, the psychiatrist's consultative roles and functions have been affected by major changes in the health care system, particularly funding. The loss of National Institute of Mental Health (NIMH) training grants has exposed a serious flaw in consultation-liaison (C-L) psychiatry: its inability to secure a firm financial base in the 1970s when it was a popular and apparently flourishing field. The decreased funding for community mental health centers (CMHCs) and the consequent restriction of programs--along with the rapid growth of mental health disciplines and the emphasis on a social, in contrast to a medical, model of mental health care--have altered the psychiatrist's role as a community consultant. A brief review of the history of psychiatric consultation and a summary of recent major developments will help us to grasp the significance of the issues--needs, concepts, practices, and benefits--confronting consultants at this time.

The Historical Background

C-L Psychiatry

In its evolution, C-L psychiatry has passed through two phases--the pioneering and the developmental--and now is at a critical point. Until the 1930s, only a few general hospitals and university medical centers had psychiatric departments; the psychiatrist's consultative activities were limited to traditional physician-physician consultations. We can assume that these were relatively infrequent; the first specific writing on the topic was Henry's (1929) article, "Some Modern Aspects of Psychiatry in General Hospital Practice." Based on his work with more than 2,000 consultations and an analysis of 300 consecutive referrals from medical and surgical services, Henry described the immense need for psychiatric consultations and emphasized the value of the psychiatrist's work in the general hospital. His choice of the word "modern" in the title of the 1929 article is dismayingly apt

today. In addition to his comments on the limited knowledge of psychiatry displayed by physicians and surgeons and the necessity for increased education, he discusses "the source of error"--their failure to recognize patients' emotional illnesses, delayed psychiatric referrals, the unscientific attitude toward functional illness, and "traditional medical resistance to psychiatry."

The Pioneering Phase

The pioneering phase began in the 1930s with the innovative efforts of a few workers. At the Colorado Psychiatric Liaison Department, Billings (1936, 1939) emphasized the educational aspects of C-L work, especially for medical students and nonpsychiatric physicians. The rapid growth of psychosomatic medicine in the 1930s led to increasing interest in C-L activities. World War II provided a medical laboratory for the psychosomatic approach to patients and also brought psychiatrists into close association with their medical colleagues. After the war, psychiatry entered the general hospital. The medical practitioners' responsibility for their patients' psychiatric problems was emphasized by Kubie (1948), Kaufman and Margolin (1948), Levine (1942), Bibring (1956), and others. Kaufman organized the psychiatric department at Mount Sinai Hospital in New York around the roles and activities of C-L psychiatrists who were assigned to particular wards and clinics.

The Developmental Phase

The developmental phase began in the late 1950s, marked by the publication of Weisman and Hackett's (1960) article, "The Organization and Function of a Psychiatric Consultation Service," which described the "therapeutic consultation" and the necessity for a patient rather than a disease orientation. Also, the conceptual base for C-L psychiatry was enlarged by Meyer and Mendelson's (1961) analysis of the complex patterns and processes involved in referral and consultation.

During the 1960s a large number of organized C-L programs were launched to: (1) systematize consultation activities and (2) provide some training in the principles and practices of psychiatry for nonpsychiatric physicians. Mendel (1966) reported that 75 percent of 202 psychiatry training sites provided C-L training.

Based on the work of Balint (1957), Beigler et al. (1959), Schiff and Pilot (1959), and Meyer and Mendelson (1961), the consultee-oriented approach developed. The consultant's activities were no longer limited to specific diagnostic or treatment

services but were enlarged in scope to include greater involvement with the referring physician. Such work led to the development of a third model in the 1960s, the situation-oriented approach, which extends the consultant's work to the total patient milieu. Nursing staffs, in particular, welcomed the expanded programs. Social workers also quickly became involved in C-L work. By the 1970s, the C-L team, consisting of at least a psychiatrist, trainees, a C-L nurse, and a social worker, began to function in some medical centers.

The growth of C-L psychiatry accelerated in the mid-1970s. Its status was recognized by the American Hospital Association's report on Mental Health Services and the General Hospital (1970) which emphasized that C-L psychiatry serves many of the otherwise unserved and that it contributes to the quality of care in the hospital, and also affects hospital utilization. The American Board of Psychiatry and Neurology made C-L training mandatory and in 1974 the Psychiatric Education Branch of NIMH gave C-L training a high priority for funding. Schubert and McKegney's (1976) survey of medical school departments of psychiatry showed that at least 96 percent of them taught C-L psychiatry.

The Community Consultation

As described in a recent report of the Group for the Advancement of Psychiatry (1983), early in this century three influences--the mental hygiene movement, Adolf Meyer's public health programs, and the child guidance movement--led to the development of community psychiatry and to the psychiatrist's role as a community consultant. Community psychiatry evolved slowly during the 1920s and 1930s. But after World War II, the public was shocked by the deplorable conditions in the State hospitals, many of which had become overcrowded barracks and provided little more than basic custodial care for patients. The discovery of psychotropic medications in the mid-1950s and vigorous moves away from asylum care in Europe stimulated widespread interest in community psychiatry. To implement some of the recommendations made by the Joint Commission on Mental Illness and Health (Action for Mental Health 1961), Federal legislation in 1961 and 1963 created the Community Mental Health Centers (CMHC) program. Community consultation and education was one of the five essential services required of CMHCs that received Federal funds.

Building on Lindemann's (1956) crisis theory and principles of crisis intervention, Caplan (1961), Haylett and Rapoport (1964), Bellak (1964), and others rapidly developed the theory and practice of community consultation for psychiatrists. In the 1960s,

many residency programs began to include community psychiatry rotations for trainees. The indirect or mental health consultation became an established approach. Caplan's later volume (1964) Principles of Preventive Psychiatry and Lamb and his colleagues' (1968) Handbook of Community Mental Health Practice were widely used textbooks for psychiatric residents.

In the 1960s, the psychiatrist's consultative activities in the community expanded greatly. The emphasis on community mental health and relatively ample funding stimulated school systems, various community agencies, courts, correctional agencies, and others to employ psychiatrists as part-time consultants. In those settings, the psychiatrist usually conferred with administrators, discussed "problem" cases with the regular agency staff, and evaluated clients thought to be manifestly mentally ill or complicated cases.

But during the 1970s, the psychiatrist's roles and functions as a consultant in the CMHCs began to shrink. The centers tended to emphasize primary prevention and used their dwindling resources to provide only minimal care in the community for the increasingly large numbers of deinstitutionalized chronically ill patients. The average number of psychiatrists working in a CMHC fell from 6.8 in 1970 to 4.3 in 1976 (NIMH 1978). Although many leaders in American psychiatry had enthusiastically promoted the community mental health movement and had jumped on the CMHC bandwagon in the 1960s, the direction taken by the CMHCs led to demedicalization. The psychiatrist's consultative role was restricted, sometimes limited to "med-checks" (writing prescriptions requested by mental health workers for maintenance psychotropic medications for patients) or to evaluations for hospitalization. As financial support declined and the once-fervent interest in community mental health waned, psychiatric consultations to schools, social agencies, the courts, and correctional agencies were reduced drastically. Agencies tended to use their increasingly limited funds primarily to support the mental health professionals on their regular staff and obtain consultations from community mental health centers or from mental health professionals whose services were not as costly as psychiatrists'.

A summary of recent theoretical, clinical, and educational developments and of evaluation studies helps us to appraise the psychiatrist's consultative roles and functions in the 1980s.

Theoretical Developments

C-L Psychiatry

Two developments at the conceptual level are influencing C-L psychiatry. One is the biopsychosocial model of disease and illness elaborated by Engel (1977, 1980). The other is the application of principles of general systems theory (Von Bertalanffy 1968) and of the theory of living systems (Miller 1978) to C-L practices--"systems" approaches.

The Biopsychosocial Model

Engel (1977) described the limitations of the current biomedical model of disease. It is linear in that it emphasizes simple cause-and-effect relationships. It is reductionistic in that it concentrates on one organ or part at a time, not the person. It is dualistic inasmuch as it separates the patient's body both from the patient's personhood and from the social situation in which the patient lives. Engel's (1980) biopsychosocial model calls for more than simply consideration of relevant psychological, social, and biological factors involved in the individual's disturbance. It requires that the physician account for the patient's dysphoria and dysfunction and the decision which led the patient "to seek medical help, adopt a sick role, and accept the status of patienthood" (1977, p. 133).

The biopsychosocial model embodies principles of general systems theory. As a paradigm it should have greater explanatory power and potential utility than the biomedical model of disease. Engel (1977) concludes that the biopsychosocial model "provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care" (p. 135).

Edelstein et al. (1982) and Schultz et al. (1982) described the use of the biopsychosocial model in C-L work. Their case histories illustrate the interplay of biopsychosocial factors in the development of patients' disturbances and in the multilevel interventions for treating emotionally ill medical patients. Workers in C-L psychiatry are enthusiastic about this model; however, a new model in any scientific field must be tested and evaluated by rigorous research which measures its utility and limitations before it will be accepted.

Systems Approaches to C-L Practices

The development of general systems theory led to the question: Can an understanding of systems theory give the psychiatrist a broader, deeper, and sounder conceptualization of the processes involved in the medical patient's distress and of strategies for effective management? The evolution of C-L psychiatry has been characterized by the adoption of successively broader, more complex conceptual and clinical approaches. The patient-oriented approach had showed that the psychiatrist could contribute to the care of general medical patients. But experience soon revealed the need for expanded approaches such as the consultee-oriented, and the situation-oriented approaches. Also, salient aspects of Kurt Lewin's (1951) field theory were found to be applicable to C-L psychiatry. An example is the concept of the group culture (e.g., ward personnel) with its norms, values, and beliefs; intragroup conflict arises when norms are challenged or when the group is changed by the loss of leaders or by the entrance of new members (Mohl 1981). Wise and Goldberg (1979) point out that to work effectively the C-L psychiatrist cannot be seen as an advocate of norms and values which clash with those held by the staff.

In 1973, W.B. Miller (1973a and 1973b) discussed issues confronting the C-L psychiatrist from the perspective of general systems theory. He pointed out that the consultant can interpret patient data at three levels--the biological, psychological, or sociological--and that any one of them may be correct, but how the patient is perceived and what is done for the patient varies according to the particular level emphasized by the consultant. Furthermore, the consultant can make seven decisions about the data: the level considered, the primary focus chosen, the conceptual systems used, the time span for collecting the data, the stressors identified and defined, the processes emphasized, and the disposition selected. Miller's case histories illustrate the applicability of systems theory to C-L psychiatry; his discussion of case formulation based on a systems approach is especially valuable.

Glazer and Astrachan (1978-79) emphasize that the C-L psychiatrist needs a greater understanding of organizational variables. Medical units are open systems which interact continually with the environment. Management is concerned with regulating boundaries and with moderating relationships of the parts of the organization to each other (intrasystem) and of the organization to the environment (intersystem). Their case histories show that the organizational systems in the hospital can be stressful; poorly delineated, unmanageable boundaries or unclear,

conflict-laden authority relationships can produce or intensify stress. The systems approach enables the consultant to work with sources of stress in an organized fashion.

Elements of general systems theory enlarge the consultant's theoretical framework. They show the deleterious influence of intrasystem and intersystem disruptions on patients and point to avenues for successful interventions. Mohl (1981) emphasizes the need for research to determine the efficiency of specific strategies based on general systems theory--for example, studies of outcome measures and comparisons of various systems in the hospital. The latter could lead to the development of a typology of various units which would "make the design, targeting, and evaluation of liaison psychiatric interventions more effective" (p. 110).

Community Consultation

Many psychiatrists consulting with CMHCs, agencies, and schools believe that a systems perspective is applicable to their work. The regulation of boundaries, division of labor, and definition of the primary task are some key concepts influencing intrasystem and intersystem functions and conflicts. Conflicts which surfaced as interdisciplinary rivalry and as territorial struggles in the 1970s diminished the effectiveness of CMHCs. Fruitless struggles about the social versus the medical model (which have waned recently), along with budgetary cutbacks and reductions in programs, have inhibited conceptual developments in community consultation during the last few years.

Clinical Developments

C-L Psychiatry

During the last few decades, repeated studies indicate that about 30 percent of all hospitalized general medical and surgical patients suffer from significant psychological disorder. However, on average only 2 to 3 percent of hospitalized patients are referred for consultations.

Three studies (Karasu 1978b; Ries et al. 1980; and Craig 1982) describe representative consultation practices. Generally, about twice as many female as male patients are referred. The average (and usually the median) age of the patient is in the early forties. During the last few years, a larger number of patients in the age group 20-39 have been referred than in the past. The number of elderly patients referred appears to be quite low; Craig

(1982) suggests that their needs for consultation are not being recognized. The percentages of patients from various ethnic groups or socioeconomic classes vary considerably, depending upon the type of hospital, the population it serves, and the activities of the C-L service. In a study of referring physicians' perceptions of general medical inpatients' emotional distress, we (Schwab et al. 1967) found that physicians tended to be much more aware of the emotional distress of their upper- and middle-class patients than that of their lower-class patients. We attributed this significant finding to social distance.

The evaluation and treatment of depression and organic brain disorders are two common reasons for consultation (Lipowski and Wolston 1981; Ries et al. 1980). Most reports indicate that few patients are referred for alcohol or drug abuse; the low referral rate may reflect physicians' inability or unwillingness to diagnose alcoholism. Craig (1982) notes that patients with classical psychosomatic disorders are referred infrequently.

The consultants' most frequent services were found by Karasu (1978b) to be evaluation of mental status and suggestions for management. Ries and his colleagues (1980) reported that the consultants' most frequent functions, besides evaluation, were providing psychotherapy, referring for outpatient psychotherapy, transferring to an inpatient psychiatric facility, and supporting the staff.

Role of the C-L Psychiatrist

During the last 50 years, the C-L psychiatrist's role has expanded to include several essential functions: (1) to provide specialized knowledge and skills, (2) to educate, (3) to work collaboratively with nursing and other hospital personnel, (4) to conduct research, and (5) to be an expert in human behavior and humanistic medicine.

Recent findings emphasize the importance of the consultant's having a working knowledge of general medicine. There is a great deal of concern about diagnosing and treating the large number of patients with organic brain disorders and the elderly with pseudodementia (Glickman 1981; Lipowski 1983). Also, Popkin et al. (1982) showed that consultants frequently recommended diagnostic examinations which revealed previously unrecognized physical illness.

Ries et al. (1980) point out that the role of the C-L psychiatrist has been broadened by findings from the clinical social sciences. It is important for the consultant to evaluate "illness"

considerations: the person's decision to adopt the patient role, the meaning of the sick role, and behavioral responses both to illness and to caregivers.

Knowledge of the clinical social sciences and of general systems theory also enhances the consultant's educational work. Engel (1982) states that the C-L psychiatrist should teach the principles of biopsychosocial care to his or her colleagues. Exerting a humanizing influence on patient care is fundamental to all aspects of the C-L psychiatrist's role.

Critical Care Medicine

C-L psychiatry has been influenced by the rapid technological advances in medical care. In the 1960s, the development of dialysis units and the successes of intensive care units (ICUs) and coronary care units (CCUs) altered patterns of disease and treatment, led to the prolongation of life (often with psychosocial and other sequelae), and revealed relatively new, or at least different, aspects of psychiatric illness coexisting with life-threatening physical illnesses. Also, the nursing and other intensive care personnel have been found to need psychiatric support systems to prevent stress and burnout (Vreeland and Ellis 1969).

Since 1970, the number and types of special hospital units have proliferated. Greenhill (1977) points out that critical care medicine has led to iatrogenic problems related to bioethical considerations, which, along with the techniques required to cope with urgent, often complex situations and procedures, have significant implications for C-L psychiatry. He mentions the emergence of such new syndromes as the catastrophic reaction (in which a patient appears to be in a state of suspended animation 3 to 5 days after open heart surgery) and unusual patterns of hypomania, catatoniclike episodes, and apathetic states which are difficult to diagnose. Also, there are new opportunities to study patients' cognitive processes and high levels of anxiety related to continuing life and death issues, to body image distortions, and to denial in the face of "the certainty of mutilation and at the edge of death."

Greenhill (1977) concludes his superb discussion of critical care medicine with comments on the developing role of the psychiatrist as the primary care physician. He observes that because critical care physicians and surgeons are intensively involved with the technological intricacies of patient care, the patient may be in emotional isolation. In such a complex situation, the psychiatrist "takes over the doctor-patient

relationship" and sometimes "is left as the primary care physician" (p. 167).

An example of some of the outstanding results of C-L psychiatry in the CCU has been presented by Cassem and Hackett (1971). Consultations were requested for 32.7 percent of 441 consecutive patients admitted; the most frequent reasons for referral were anxiety, depression, and management of disturbed behavior. Psychiatric interventions included medications, clarification of problems, environmental changes, and supportive psychotherapeutic techniques. Mortality in the referred group was only one-third of that expected in the CCU even though the patients who received consultations did not have more serious heart disease than the others.

Many persons undergoing coronary artery bypass surgery have benefited from the work done by C-L teams. The preoperative "psychological" preparation of the patient and the family has become an important clinical consideration that is now being carried out by the cardiac surgeon or team members. When the psychiatrist is called upon to work with these patients post-operatively, the most common problems encountered are protracted postoperative delirium or depression.

Recent research points to the importance of C-L psychiatry in critical care medicine. Lown and associates (1980) described the significance of psychophysiologic factors in sudden cardiac death. They concluded that: "The involvement of psychiatrists, psychologists, and cardiologists in a multidisciplinary approach to managing patients at risk for sudden death from ventricular fibrillation is yielding significant insights and prolonging their lives."

Treatment

Interest in the psychotherapeutic aspects of the consultation has emerged recently. Early C-L literature, in the 1935-1960 era, described the therapeutic benefits of skillful interviewing. But as C-L psychiatry developed in the 1960s and 1970s, the psychotherapeutic aspects of the consultation were overshadowed by an emphasis on psychotropic medications and on management.

We (Schwab and Kuhn 1979) used patients' reactions to medical illness as a model which provided guidelines for realizing the therapeutic potential of the consultation. Patients' reactions can be seen as four relatively distinct stages: anxiety, defensiveness or bargaining, relative acceptance, and convalescence or recovery. We outlined therapeutic strategies and goals for each of the stages.

In discussing psychotherapy with somatically and psychosomatically ill patients, Karasu (1978a, 1979) emphasizes the importance of creating a climate of warmth and acceptance, of using flexible techniques that include "consideration of the broad dimensions of psychosomatic theory and practice" (1978a, p. 79), and of individualizing the approach to each patient with special attention to the patient's character structure. Some significant concerns are the patient's misconceptions about illness, undue fears of vulnerability and mortality, understanding of the psychiatrist, secondary gain, and responses to illness. Premature interpretations can increase resistance to therapy or aggravate somatic illness. Greenhill (1980) maintained that in C-L psychiatry there are five core psychotherapeutic areas: (1) the critical event (e.g., stressful life events or iatrogenic crises); (2) phasic monitoring (an emphasis on the onset, course, and remission, not necessarily cure, of the disease); (3) maintenance therapy; (4) treatment of communicative ego defenses (poor communication of effect); and (5) active therapeutic intervention.

To enhance the therapeutic potential of the consultee-oriented consultation and of liaison work, Schubert (1978) advocates a cautious, low-key approach to referring physicians and an emphasis on the consultation as a collaborative endeavor. Concrete steps that increase the effectiveness of liaison work include: (1) acknowledging the primacy of the attending physician, (2) avoiding criticism of lack of knowledge about psychiatry, (3) not applying diagnostic labels to physicians and staff members, (4) admitting freely that C-L work is different (5) avoiding behavior that appears "eccentric," (6) serving on hospital committees, (7) discussing collaborative research when others are interested, and (8) attending medical staff functions.

The Community Consultation

In community settings, the psychiatrist usually conducts indirect consultations on difficult cases but sometimes sees the client personally (along with the mental health worker) for diagnostic evaluation and recommendation for management. The psychiatrist's psychotherapeutic model is not entirely appropriate; psychiatrists function best by blending models and procedures flexibly and by retaining their identity as physicians. Also, the psychiatrist is responsible for ensuring that the client has had a medical evaluation recently or is not suffering from an untreated physical disease. With demedicalization of the CMHCs in the 1970s, the psychiatrist's consultative role often became both limited and circumscribed.

Donovan (1982) states that "It is much harder to practice psychiatry in a CMHC than anyone originally foresaw." She mentions the lack of reports on daily work in CMHCs and what it entails. In her experience, a very large number of CMHC patients required direct psychiatric care. Although indirect services were needed, there was inadequate time for evaluations, consultations, and case supervision; "the psychiatrists experienced a constant overloading of their problem-solving abilities" (p. 459). Despite such difficulties, she maintains that CMHCs are treating patients close to their homes and as persons, not "psychological lepers."

Lamb and Peterson (1983) recently described what they call the new community consultation. Concern about the plight of seriously ill chronic patients in the community is leading to their being given a higher priority for care than in the past. Since many of them are lodged in residential facilities managed by administrators or by facility operators (many of whom have had no clinical training), there is a dire need for mental health consultations.

When consulting in these facilities, Lamb and Peterson emphasize that the psychiatrist should first obtain: (1) an understanding of the facility's administrative problems, (2) some familiarity with the consultee's job situation, and (3) knowledge of recent evaluations of the facility and of its limitations. The consultant's goals are to model therapeutic action and thereby teach the consultee how to deal with similar problems in the future. Problems presented to the consultant pertain to the "house" government of the facility, the setting of limits for patients, the operator's lack of knowledge of the mental health system, crisis management, alcohol and drugs, and dealings with families. Despite difficulties, Lamb and Peterson conclude that the new "mental health consultation can be widely used as an important therapeutic modality" (p. 64) for long-term patients.

Educational Developments

C-L Psychiatry

Education has consistently been one of C-L psychiatry's three major purposes, ranking second only to patient care and ahead of research. In Greenhill's (1977) words, "The mission of liaison psychiatry, the thrust, has been to proselytize" (p. 147). As programs developed rapidly in the 1970s, the C-L faculty began to teach an increasing number of medical students, psychiatric residents, other residents, C-L fellows, attending physicians, nurses, social workers, and students in other mental health disciplines.

The development of the competency-based curriculum in the mid-1970s supplied a model for C-L education consisting of overall learning objectives or goals, specific learning objectives for the acquisition of knowledge and skills, instructional methods for attaining the specific learning objectives, and evaluation procedures. The emphasis is on learning behavioral skills and demonstrating that they can be used effectively by the trainee.

Haupt and his associates (1976-77a, b) described the application of the competency-based curriculum to three C-L psychiatry areas: data gathering, case formulation, and clinical intervention. Russell, Weinstein, and Haupt (1976-77) maintain that programs can use the competency-based model to address such issues as program design, the integration of C-L psychiatry into general psychiatry, and the relationship of C-L psychiatry to medicine.

We have found that one of the major advantages of the competency-based curriculum for C-L work is that it can be modified for students and trainees at various educational levels. The overall and the specific learning objectives, methods of instruction, and evaluation procedures for the medical students can be a simpler, shorter form of the curriculum used for residents and, in turn, the curriculum for fellows or advanced trainees can be a highly developed, lengthier form of the basic curriculum. Appropriate modifications can be made for students and trainees in nursing, psychology, social work, and other mental health disciplines.

The importance of C-L training in the psychiatric resident's maturation has been discussed by Granet, Perry, and Talbott (1980). C-L psychiatry and community consultations allow residents to adopt a therapeutic stance, to apply psychodynamic theory to the consultation system itself, and to teach without the use of jargon.

The experience as a consultant facilitates the transition from residency to the outside world, not only through attitudinal changes achieved by exposure to less structured settings, a change in the supervisory model, and a solidification of identity as a physician and psychiatrist, but also by providing the resident the opportunity to begin de-cathecting from the training program (p. 306).

Some teaching programs use C-L teams consisting of a faculty member, psychiatric resident, nurse clinician, social work clinician, and students and trainees. Guggenheim (1982) maintains that the "medical team rounding model" can enhance the educational efforts of C-L psychiatrists.

The growth of C-L services during the 1970s sometimes attracted an overwhelming number of trainees from various disciplines. Lipowski (1981) contends that limits must be set since the major educational goal of C-L psychiatry is to "help prepare future physicians to identify, manage, and properly refer psychiatric and psychosocial problems encountered in their practice." Consequently, teaching efforts should be focused on medical students.

Recently, Tilley and Silverman (1982) sent questionnaires to 110 medical school departments of psychiatry; 76 percent of the departments responded. The average time in residency allocated to C-L training was less (6-7 percent in 4 years) than was indicated by Schubert and McKegney's earlier (1976) survey (10 percent in 3 years). Telephone followup with the nonrespondents revealed that they either had no organized C-L program or lacked sufficient data to respond. Tilley and Silverman (1982) expressed concern about: (1) the relatively small percentage of total departmental faculty time, 6 percent, allocated to C-L training; (2) the fact that only 34 percent of programs had multidisciplinary staffs; and (3) the lack of systematically collected data even though computerized data bases are available (Trainer et al. 1979). They concluded that "recent estimates of the growth and robustness of C-L psychiatry are more optimistic than is justified by our data."

A review of the literature discloses little or no evaluation of psychiatric residents' and fellows' C-L training. Cohen-Cole (1980) found only nine evaluations of the outcome of nonpsychiatrists' training. An excellent early study by Greenhill and Kilgore (1950) reported educational efforts helped 38 percent of the medical house staff to learn the effective use of psychotherapeutic techniques in everyday medical practice; 21 percent acquired minimal skills, and 40 percent none. A patient outcome study by Adsett and Rudnick (1978) showed a 200 percent increase in the number of psychiatric diagnoses, a 300 percent increase in psychiatric consultations, and a 400 percent decrease in psychiatric hospitalizations and emergencies after a psychiatrist worked one-half day per week as a member of an outpatient team in a family practice setting. McKegney and Beckhardt (1982) maintain that physicians' perceived needs for psychiatric education have been well documented. They are interested primarily in practical and treatment-oriented education rather than education on the psychosocial aspects of disease that often is favored by psychiatrists.

A recent survey of family medicine residency training directors by Berlin et al. (1983) indicated that the psychiatric training of family practice residents often is limited to roles (e.g.,

supervision and direct consultation) set for them by family medicine. Forty-eight programs used behavioral scientists to train their residents in the psychosocial aspects of patient care. This may indicate that family physicians are more comfortable with behavioral scientists than with psychiatrists or that C-L psychiatrists were not available.

Most evaluations of C-L education have focused on trainees' cognitive attainments, that is, on their acquisition of knowledge and skills; there has been little evaluation of the subjective and objective components of attitudinal and psychomotor domains. At the University of Louisville we are developing a comprehensive evaluation system to assess medical students' and psychiatric residents' performance as perceived by the trainee, the patient, and the referring staff, as well as by the faculty.

Community Consultation

Although training in community psychiatry is required of psychiatrists by the American Board of Psychiatry and Neurology, there is a "diminishing emphasis on community psychiatry in residency training programs" (Group for the Advancement of Psychiatry 1983). In the 1960s, innovative training programs were launched. Since then, many of the principles and practices of community psychiatry have been incorporated into the psychiatric residents' training in the emergency room, outpatient clinics, and inpatient units in the general hospital. Some programs, especially those affiliated with CMHCs, have formal community psychiatry rotations, but others offer those rotations only as electives.

Ribner (1980) points out that the exodus of psychiatrists from the CMHCs in the late 1970s has been attributed to role diffusion and to hostility of the nonpsychiatric staff; however, many of these psychiatrists have just completed training and "were generally unprepared for the new situations they faced at the community facility" (p. 340). In view of the need to provide care for chronic patients, White and Bennett (1981) describe a special residency curriculum. It includes didactic sessions and 4 hours of work per week for 6 months in a chronic care facility for second- and third-year residents. Residents are expected to develop skills in rehabilitation and supervision as well as in community consultation.

Psychiatric residents at the University of Oregon spend their entire third year of training in CMHCs. The curriculum emphasizes community support systems. It includes seminars, supervision oriented toward the care of the chronically ill, and clinical electives. The mental health consultation is one of seven major

skills to be acquired by trainees. Although this program has not been formally evaluated, 80 percent of the graduates during the last 3 years have begun working in the public sector (Cutler et al. 1981).

Evaluation of C-L Psychiatry

Authorities in C-L psychiatry deplore the lack of evaluation studies. Greenhill (1977) states that their paucity is surprising, and Lipowski (1979) asserts that "evaluative research is almost non-existent." Nevertheless, McKegney and Beckhardt's (1982) comprehensive review of evaluation research in C-L psychiatry from 1970 to 1981 cited 182 references to the topic. Importantly, there was a significant shift in evaluation research during the 1970s from descriptive studies (decision-oriented research) to studies of the results of patient-care and educational programs (conclusion-oriented, outcome research). McKegney and Beckhardt cite only 4 decision-oriented and 11 conclusion-oriented evaluation studies in the 1970-75 period compared to 22 and 29 studies respectively in the years 1976-81. Studies of the outcome of consultation showed generally that it was beneficial and decreased psychiatric morbidity.

Cohen-Cole and Friedman (1982) evaluated the attitudes of 200 nonpsychiatric physicians toward consultations. The physicians reported that 37 percent of their patients had significant psychological disorders, but that consultations were indicated for only 11 percent. Two-thirds of the physicians reported a high level of satisfaction with consultations most of the time. They ranked the services proved by consultations (from most to least valuable) as follows: (1) patient disposition, (2) increased psychosocial understanding of patients, (3) the direct treatment of patients, (4) the formal psychiatric examination, and (5) services to the staff.

Assessing physicians' compliance with C-L psychiatrists' recommendations supplies essential data for evaluating C-L services. Popkin, Mackenzie, and Callies' (1983) consultation-liaison outcome evaluation system (CLOES) has shown that compliance with psychiatrists' recommendations varied according to the recommendations: psychotropic medication, 63 percent compliance rate; further diagnostic tests, 53 percent; and representation of the psychiatric diagnoses on the patients' charts, 43 percent. Popkin and his colleagues maintain that consultees are particularly receptive to recommendations about patient management.

Such findings support McKegney and Beckhardt's (1982) contention that the issue of compliance is serious; patients and consultees comply with less than two-thirds of the recommendations made to them. They ask: "Should we aim at increasing consultee/patient compliance or rather at reducing the number and/or type of recommendations made, limiting them to those that are the most valid, feasible, and necessary for the patient's care?" (p. 212).

Costs and Benefits of C-L Psychiatry

The Cost of C-L Programs

Throughout the years C-L programs have lacked a firm financial base. University departments of psychiatry have seldom done more than supply the salary of the C-L program director, while other departments--the recipients of C-L services--have given little or no support. For example, the well-established department of consultation-liaison at the University of Rochester, New York, obtained 10 percent of its support from the department of medicine, 15 percent from the department of psychiatry, and 5 percent from the medical school; 65 percent was from training and research grants (Greenhill 1977). Guggenheim (1973) emphasized that the low reimbursement for C-L services has had a dampening effect on the recruitment of faculty and fellows and on the development of programs. Recently, Guggenheim (1978) advocated the development of a "market-place model" to increase revenues.

Financial problems are also revealed by Tilley and Silverman's (1982) recent survey. Only 31 percent of C-L training programs were able even to "estimate" payments for services; 42 percent of the patients receiving consultations were nonpaying, 30 percent were partial-paying, and only 28 percent were full-paying. An analysis of funding sources showed that 45 percent of the training programs were funded almost completely by a university, 13 percent by a university and C-L grants, 13 percent by a university and hospital billings, and 9 percent by a hospital.

The Benefits of C-L Programs

A convincing demonstration of the clinical benefits of C-L psychiatry is supplied by Popkin and his colleagues' (1982) analysis of 793 consultations in a university teaching hospital. For 302 patients, the consultants recommended further diagnostic action involving psychological testing, procedures such as the encephalogram (EEG), or brain scan, laboratory determinations,

hematologic studies, or urine studies. Abnormalities were found in 63 percent of the patients for whom psychological testing was recommended, 50 percent of those for whom further procedures (e.g., radiographic studies) were recommended, and 41 percent, 49 percent, and 21 percent respectively of those for whom laboratory determinations, hematologic studies, and urine studies were recommended. These impressive results show that the low compliance with psychiatrists' recommendations cannot be attributed to "poor diagnostic recommendations" and point to the necessity for the C-L psychiatrist to have a substantial medical background.

Studies are also demonstrating the benefits of C-L psychiatry to the hospital staff and in reducing the cost of medical care. Dubovsky and his colleagues (1977) gathered data on two units, a coronary care unit (CCU) in which C-L activities were supplemented by regular group discussions with the nurses (the experimental unit) and a similar unit in a comparable hospital in which a C-L psychiatrist was available to the medical staff only for consultations (the control unit). The nursing group discussions centered on patients' problems, the nurses' reactions to these problems, administrative and leadership problems, as well as on such topics as depression and the dying patient; nurses' personal problems were not discussed. After 18 months, the nurses on the experimental unit were using their clinical skills more than in the past and were more aware of and better able to manage patients' emotional problems. In contrast, the nurses on the control unit were spending less time directly with patients than before the study started. Dubovsky and his colleagues state that "a calmer, smoother-running CCU in which open communication is fostered may have a dampening effect on potentially dangerous emotions in all its patients" (p. 26). Before the study began, the mean mortality on the experimental unit was significantly higher, 9.8 percent, than on the control unit, 6.2 percent. During the first 15 months of the study, the mortality rate on the experimental unit decreased significantly to 6.6 percent; the rate on the control unit increased slightly from 6.2 percent to 6.3 percent.

The clinical and cost benefits of liaison psychiatry have been shown by Levitan and Kornfeld's (1981) study of 26 elderly female patients with fractured femurs admitted to an orthopedic unit and followed by a C-L psychiatrist during a 6-month period (the liaison group) compared to 26 patients who had been admitted to that unit the previous year and were not seen by a C-L psychiatrist (the control group). In the liaison group, 17 of the 26 patients showed psychopathology. The results are impressive. The median length of hospital stay for the liaison group was 30 days compared to 42 days for the control group. Furthermore, in the liaison group, 16 patients went directly home (rather than to a nursing home) from the hospital, compared to only 8 of the patients in the

control group. Levitan and Kornfeld estimated that the part-time work of the liaison psychiatrist, which cost only \$10,000, would result in a projected annual savings of \$193,000 in the cost of medical care for the patients in the liaison group.

With the introduction of diagnostic-related groups (DRGs) as the basis for third-party reimbursement to hospitals, more efficient hospital care is being seen by hospital administrators and third-party carriers as mandatory. Inasmuch as medical patients with psychological disorders generally have a longer hospital stay than those who have only physical illnesses (Schwab 1968), increased C-L work could likely reduce the length of many patients' hospitalizations and thus decrease the cost of medical care.

Conclusion

Despite the continuing need for C-L services and significant clinical, educational, and scientific developments, C-L psychiatry is at a critical stage in its evolution as the result of the stripping away of its financial support. Pasnau (1982) recently declared that C-L psychiatry is "at the crossroads." In addition to the financial crisis, it is confronted by challenges resulting from lack of conceptual clarity, "competition between the 'consultation model' and the 'liaison model'" (p. 989), its low priority with departments of psychiatry compared to traditional inpatient and outpatient programs, and such political issues as those arising from the emergence of behavioral medicine. At the most fundamental level, however, the core question is why C-L psychiatry was not able to establish a solid financial base in the past decade when the need for and benefits of its services were recognized.

In a historical perspective, we can see that the fundamental problems limiting the status of C-L psychiatry, problems described by Henry (1929) more than 50 years ago, are largely unsolved. At the tip of the iceberg, an enduring difficulty is the failure of physicians to diagnose and provide treatment for their medical patients with emotional distress. For more than 50 years leaders in the field had hoped that the development of C-L programs and increased psychiatric education for medical students and practitioners would be a remedy. However, the difficulty persists even though there have been C-L programs in most medical centers for at least 15 to 20 years and psychiatric education for medical students and continuing medical education programs have flourished. Insufficient knowledge, therefore, does not seem to be a plausible explanation.

In a recent article I (Schwab 1982) listed seven major reasons for physicians' continuing failure to diagnose and provide

treatment for patients with emotional distress. The first is the influence of the biomedical model of education presented to students during an impressionable period of their lives. The second is that medical education and training require students and trainees to construct elaborate personal defenses which increase their emotional and social distance from patients. A third reason is that physicians are unaware of the extent to which their own pejorative attitudes and countertransferences can distort their views of medical patients with psychiatric illnesses. Other reasons are social distance, neglect of the patient's case history, the failure to conduct a mental status examination, and the diagnostic complexities presented by psychiatric and medical conditions which simulate each other.

Nonpsychiatric physicians' difficulties with the identification of medical patients with psychological disorders are well documented and are apparent. But scarcely below the surface is the age-old problem of resistance by the medical profession and the public to psychological disorders and psychiatry. Broad societal and cultural influences are significant reasons not only for continuing difficulties with the diagnosis and treatment of medical patients' emotional disorders, but also for this public resistance to psychiatry. In his definitive studies of the history and sociology of medicine, Henry Sigerist (1960) emphasized that the position of the sick in a society, the care they received, and the role of the physician were determined primarily by the social and economic structure of the society and its "valuation of health and disease" (p. 20).

Politically, our society has been retrenching during the last few years and it appears that at least moderate conservatism will prevail in the 1980s. In such a political climate, the visibility of the mentally ill declines. Our society shows no indication of a readiness to enlarge the epidemiologic net--to see any of the mentally ill except those who are markedly disturbed. Thus, C-L psychiatry is sailing against the wind in the 1980s precisely because its purpose, its major endeavor, is to increase the identification of otherwise unnoticed patients suffering from psychological disorders and emotional reactions to physical illness and to provide treatment for them. Already, drastic Federal, State, and local cutbacks in funding for mental health services are indisputable evidence of the low "valuation" of mental illness. This valuation, which seems to be much lower than it was 10 years ago, is reinforced by stigma and also by the increasing use of social control measures--rather than treatment--to minimize the visibility of mental illness in our society.

The vitality of C-L psychiatry in the 1980s appears to be at stake. Hales and Fink (1982) emphasize that C-L programs are

necessary for total patient care and should be supported by the hospital administration from funds obtained by contracts with third-party carriers and Medicare and Medicaid. Such funding is more than justified by the need for C-L services and their clinical and educational benefits, as well as by the financial benefits that have been noted. But, as Hales and Fink observe, such a drastic change in funding would require changes in attitudes and unambivalent support from such powerful bodies as the American Medical Association, the American Hospital Association, and the American Psychiatric Association. Unfortunately, history discloses that attitudes toward the mentally ill change very slowly, at times imperceptibly, and in the current political climate it is unlikely that C-L psychiatry will be given a high priority by the major institutions that determine health care practices.

The new Tax Equity Financial Responsibility Act (TEFRA), which limits Medicare and Medicaid payments to hospitals for physicians' services, decreases the already-slim likelihood that a firm financial base for C-L psychiatry can be secured by making it a hospital-based service. This is happening, somewhat ironically, just at the time when evaluation and cost-benefit studies are demonstrating the value of C-L psychiatry. Also, departments of psychiatry will have difficulty increasing their support of C-L programs because funding for psychiatric education from the National Institute of Mental Health has been substantially reduced and, more seriously, because State governments are limiting their financial support of medical schools and demanding smaller classes to forestall a "doctor glut."

The most immediate consequences of the rapidly developing financial crisis appear to be a serious limitation of liaison functions and an increased emphasis on the psychiatric consultation for which the psychiatrist can sometimes obtain fees for services. Lipowski (1981) recommended that liaison psychiatrists should focus their efforts on consultations because they often involve complex diagnostic and therapeutic skills and that liaison nurses should be responsible for day-to-day liaison activities. But in view of nationwide alarm about the rising costs of medical care, nursing and other general hospital budgets probably will not fund programs which do not receive third-party reimbursement.

This appraisal of C-L psychiatry indicates that despite many accomplishments, enormous financial and other pressures will limit the vigor of the field in the 1980s. As we have seen, the need for C-L services is immense and referral patterns are stable over time (Lipowski and Wolston 1981). Furthermore, 57.5 percent of all persons with psychological disorder (almost 10 percent of the population) receive their mental health care in the primary care/outpatient medical sector and in general hospitals. Many

members of this vulnerable group, as well as deinstitutionalized chronic patients in community facilities, will need C-L service when they come to emergency rooms and outpatient clinics or are in general medical and surgical units. As the roles and functions of the C-L psychiatrist become restricted, limited primarily to traditional physician-physician consultations, it is likely that C-L services will be available mainly for persons with third-party coverage; among the less affluent only those with marked or disruptive behavioral disturbances will be referred.

We can hope that eventually C-L programs will once again expand as there is greater awareness of their benefits--clinical, educational, and financial--and as mechanisms for funding the needed services are developed. When this occurs, C-L psychiatry can build on the achievements in the field during the 1970s and early 1980s. It will also be stimulated by the rapid advances in the medical sciences. For example, work in psychoneuro-immunology is demonstrating links between the brain and the body which should yield greater knowledge about stress-related diseases. These disorders, which are now a manifest public concern, are largely in the domain of the psychiatrist and other behavioral scientists and are likely to remain there. And as CMHCs shift priorities toward increased care for seriously ill chronic mental patients in the community and "re-medicalize," we can anticipate that the psychiatrist's more traditional medically oriented consultative roles and functions in the community will expand.

The psychiatrist's consultative work with educational systems, social and welfare agencies, courts, and correctional systems continues although it is much more limited than it was 15 years ago. This decline in the psychiatrist's consultative activities in a large number and variety of community settings is evidenced by the sparseness of the literature on the topic and by a general lack of enthusiasm on the part of the psychiatric profession for this work during the last few years.

One exception to the reduction of the psychiatrist's consultative roles in the community is the slowly growing interest in consultation to business and industry. These somewhat new endeavors on the part of both psychiatrists and industry reflect the temper of the times in this country in the early 1980s--the emphasis on private enterprise and the governmental encouragement of business and industry. Businesses and industries have developed employee assistance programs, some of which include psychiatric consultation, especially to help managers and other employees who appear to be distressed or are showing signs and symptoms of mental illness. Sometimes psychiatric consultations are sought for program development.

In summary, the consultative role and functions of the psychiatrist in the general hospital as well as in the community are being severely curtailed by reduced funding for mental health services. The slow progress that has been made during the last 25 years against resistance on the part of the public and the medical profession to psychiatry and to accepting the tragic realities of mental illness appears to have crested.

To some extent, the psychiatric consultation, both in the general hospital and in the community, seems to be completing a cycle. Fifty years ago, the psychiatric consultation developed as mainly a physician-to-physician activity. After spreading rapidly from the general hospital to the CMHCs in the 1960s and early 1970s, the psychiatrist's consultative roles and functions narrowed considerably. In the general hospital, the emphasis is on the psychiatric consultation, not on liaison work, and in the community, the psychiatrist's consultations to various agencies have lessened. We have witnessed almost a complete turn of the wheel. However, psychiatrists' consultative activities generally have been enriched significantly by the theoretical, clinical, and educational developments of the last few decades. A new wave of support for the care of the mentally ill, which will also vitalize the psychiatrist's consultative roles and functions in the hospital and in the community, is dependent upon social and political changes in our country.

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CHAPTER 6

NURSING AND MENTAL HEALTH CONSULTATION

A. Psychiatric Liaison Perspective

Lisa Robinson, R.N., Ph.D., C.S.

This paper will present a brief history of consultation in nursing, mental health consultation in nursing, the settings in which the latter occur, standards and practices in consultation as they are described in the current literature, and some issues that confront nursing as they impact and are impacted upon by consultation. The objective of the consultative process is viewed as providing indirect service to the client by helping the consultee to solve an identified problem related to resolution of the client's problem. This broad conceptualization, reflective of Gerald Caplan's (1964) philosophy of consultation is congruent with the majority of nursing literature concerning consultation today. The areas in which this process is most often operationalized are education, research endeavors, and clinical practice.

The main thrust of the paper is mental health consultation in nursing. In this area there is a definitional problem because "mental health" is ill defined. There is little consensus among mental health professionals about the meaning and descriptors of this state. For this reason it is difficult to discuss "mental health" consultation. More often the focus is actually on psychiatric mental health nursing. This focus connotes consultant-consultee interest in aspects of dysfunctional behavior. When the focus is clearly on mental health, consultee and consultant are more likely looking at strategies to promote this state, rather than to prevent mental illness (Forti 1983).

Mental health consultation occurs in schools, community agencies, and a wide variety of community organizations where the consultant has an opportunity to influence mental health practices among community groups and those agencies creating policy in the area of mental health and illness. The consultant is likely to be working with persons who are not health care providers, such as policemen, teachers, and legislators. Psychiatric nursing consultation usually connotes secondary and tertiary prevention. In these cases the consultant may be working directly with clients or with other professional health workers providing care to clients. Mental health consultation in nursing may also occur around issues of program development and administration.

These may be in schools of nursing and in health care facilities. Finally, researchers seek consultation on their proposals before data collection and during the phase of data analysis. If the investigations focus on an aspect of mental health nursing, consultation may be sought from such experts in order to better conceptualize the research problem and to ensure the most valid interpretation of the findings.

Historical Perspective on Nursing

Nursing, as an occupation, is several hundred years old; as a profession, it is relatively young. As an occupation, nursing developed its apprentices in hospital schools of nursing. Nursing theory did not exist, but related disciplines, such as medicine, shared their theories and teachers. Nurses taught nursing skills and supervised the apprentices' practica. Because of this kind of training, with its lack of a knowledge base and the absence of faculty from the same discipline to communicate that knowledge base, nursing could aptly be viewed as an occupation. On the other hand, it could be viewed as a semiprofession, based on nursing's performance of a valued service to society and its practitioners' possession of particular skills. It was not until the 1950s, however, that nursing became aware of and committed to the development of a domain of nursing knowledge from which would emerge standards and practices of the discipline. At this point, nursing would become a young profession (Brown 1948; Lysaught 1970; Montag 1951, 1959).

Increasingly, nurses took responsibility for upgrading their practices. They also committed themselves to monitoring their own functions. This is another requirement of a profession. Standards were both established and upheld by nurses. The new professional group became responsible to others but accountable to themselves and their peers (Aydelotte 1983). ♀ As sufficient numbers of nurses were prepared at the doctoral level in nursing and related fields, such as sociology and physiology, all major teaching and learning activities of nursing students came increasingly under the aegis of nursing faculty. While experts in other fields were invited to lecture, their content areas were related to nursing by nurses. The standards of the profession, its practices, and its traditions were passed on by nurses. These are the hallmarks of a profession. char. 5.1 marked

What were the forces that influenced nursing to move from an occupational status through semiprofessional to full professional status? The impetus for this movement came about through a major shift in nursing education. The issuance of both the Montag (1951) and Lysaught (1970) reports influenced the

aegis - supporting protection.
- sponsorship/ patronage

146 Impetus - moving force

movement of nursing education into the university setting, as did the 1969 American Nurses' Association statement on graduate education in nursing. This relocation influenced a new trend in research which was directed to the observation and categorization of the nursing process. Out of these efforts, knowledge about nursing practices began to emerge. Educators in the university setting were simultaneously the theoreticians and researchers developing the domain of nursing knowledge. They prepared generic and master's-level nurses to enter the health care delivery system to practice knowledge-based nursing and to teach others to do so. Supportive agencies such as the American Nurses' Association expanded their memberships, trying to develop a unified voice and a unified identity for nursing. The American Nurses' Foundation was established to guide and support research endeavors. In the past 15 years nursing journals have proliferated as clinicians, teachers, and researchers described and disseminated their contributions. Through these endeavors leaders emerged.

Training in Consultation

There are many areas of competence in nursing in which consultation is sought and for which consultants are trained. Interestingly, the most formal nursing consultations--in which consultants may be sought from great distances, are highly paid, and are expected to be prepared from extensive documents that are forwarded to them ahead of time--are conducted by nursing authorities untrained in consultation. These nurses are typically recognized for achievement in administration and teaching and, increasingly, in research. Their consultative efforts address indirect contributions to clinical nursing.

Less formal are clinical nursing consultations in which the consultant typically lives and works near the geographical area being served. The nurse with clinical expertise who is sought for consultation is often a clinical specialist with a master's degree who has had one or two courses in consultation. A consultant in this situation is usually paid less than those engaged in more formal consultative processes, and there is no expectation of extensive prior preparation or later documentation. Clinical consultation, by definition, offers direct contributions in the clinical area.

Nurses who prepare to consult by taking courses at the master's level usually have not achieved the expertise that is associated with leaders in nursing today. These potential consultants are preparing for the future. In consultation courses the graduate nursing student is exposed to various models and types of consultation and is provided with supervised experience in the

consultative process. The new graduate recognizes that there will likely be a period of 3 to 5 years in which clinical acumen will continue to develop, followed by taking on the responsibilities of teaching and supervising others. Still later, consultative efforts will be initiated. Thus, nursing is similar to other disciplines. Nurse consultants are invited to consult on the basis of their areas of expertise and achievement, not because they are trained as consultants.

Utilization of Consultants in Nursing

While the last 30 years have been a time of quickly increasing growth and professionalism in nursing, the period also has been one of divisiveness (Kalisch and Kalisch 1978). This has been caused by the proliferation of different kinds of educational preparation of nurses and efforts by each to justify their particular program. To ensure a standard of preparation, the profession has had to adhere to both State requirements and the stringent standards of accreditation agencies such as the National League for Nursing. Nevertheless while some nurses have only a diploma from a hospital school of nursing and the required coursework to sit for the licensure exam, others may have graduated from a university-affiliated program with an associate of arts or bachelor's degree. To complicate the picture, the term "nurse" also encompasses both licensed practical nurses and practical nurses. Each of these categories of "nurse" has a different educational and technical training, and each group varies in its broader perspective on nursing (Fitzpatrick 1983b).

Generally the less liberal arts background prior to specialization in nursing and the less emphasis on theory-based nursing and problem solving, the less likely the product of that educational background is to recognize another nurse as a competent leader. This response likely relates to the kind of educational program and acculturation to the profession that the nurse underwent; nurses who were taught by content specialists who were physicians and members of other disciplines may be less likely to view nurses as authorities in their own profession. Since their formative experiences were not with authorities in nursing, they may not perceive value in consultation from members of their own discipline.

Nurses who were educated in degree-granting programs are generally more comfortable seeking nurse-to-nurse consultation. They have been educated by other nurses and have been exposed to the nursing literature that subtly accustoms them to acknowledging expertise and leadership among members of the nursing profession. They have also been educated to apply theory in

clinical situations, rather than rote application of procedure. In their educational process they have become accustomed to a Socratic method of thinking, questioning, and problem solving with the guidance of a nursing preceptor. A byproduct of that experience is preparation and receptiveness to the nurse-to-nurse consultation.

Mental Health Consultation in Nursing

The first reported instance of nurse-to-nurse consultation occurred when Florence Nightingale consulted with nurses throughout the world concerning nursing education, hospital organization, patient care, and data collection (Woodham-Smith 1951). Following Nightingale, consultation among nurses was so informal as to have missed notable publication. Few nurses regarded themselves, or were regarded by others, as experts in the field with credentials worthy of consultation until after the 1950s.

After this time, formal consultation that was contracted for was carried out by well-known educators and administrators; increasingly, informal consultation was done by clinical supervisors and clinicians with special expertise. Notable among this group were psychiatric liaison nurses. They were a small group in the early 1960s whose development paralleled that of liaison psychiatrists. The former were typically located in inpatient psychiatric units within general hospitals and were on call to the general hospital to either work directly with patients with psychological problems or to consult with staff nurses on the best means of modifying aberrant behavior in these patients through the normal nursing activities carried out on the general hospital unit. Among all types of informal nurse consultation, psychiatric liaison nursing has probably grown the most during the past 20 years (Robinson 1982).

Contributions to the Nursing Literature on Consultation

In the 1960s a few reports were published by psychiatric nurses who initiated consultative efforts in the general hospital with nurse consultees (Jackson 1969; Johnson 1963; Petersen 1969; Robinson 1968). These papers focused on the clinical problems that were presented. One classic formulation on consultation was contributed by Gilbert (1960). The 1970s yielded several theoretical papers on the consultative process itself.

Deloughery et al. (1971) grappled with the meaning of mental health consultation in community mental health nursing. They

noted that differentiating mental health consultation from other models is sometimes difficult:

This difficulty is particularly apparent when contrasting a generic psychiatric consultation with a mental health consultation involving psychiatric professionals. In the case of generic psychiatric consultation, a person skilled in psychodynamic and psychiatric techniques is being utilized as a consultant by a generalist in one of the psychiatric disciplines (medicine, nursing, etc.). The focus is on giving the generalist additional knowledge and skills (p. 61).

Deloughery et al. (1971) view community mental health consultation as the "application of the consultative process by a mental health specialist in his interaction with some community caregiver(s) with the end goal of preventing mental illness and promoting mental health both in the caregiver and in his clients" (p. 62). For these authors and clinicians the consultative process provides both direct and indirect services to a client.

Sedgewick (1973) contrasted resource and process methods of mental health consultation. The process model

operates on the assumption that individuals and groups would be more effective if they could analyze and identify needed improvements in the processes by which they operate. . . . The job of the process consultant is to help the consultee to develop insight, to discover and develop his strengths and examine his weaknesses, and to educate him (p. 773).

"While this model appears more like a paradigm for psychotherapy, the goal is to prepare the consultee to make a decision in this particular instance and in future situations" (p. 773). According to Sedgewick, the vehicle for this expanded capacity is "promotion of the client's ability, knowledge, interest, and experience in diagnosing and solving his own problem" (p. 773). An issue is raised here, however, concerning the differentiation of consultation, psychotherapy, and supervision.

Marcus (1976) published another paper differentiating the resource and process methods of consultation. She recommended resource consultation as a means of helping the consultee make decisions based on a variety of alternatives and reminded nurse consultants to return patient care responsibilities to those who have responsibility for them.

Termini and Ciechoski (1981) combined a focus on psychiatric liaison nursing with a didactic presentation on process. They combined the classic triadic model which is termed "consultation" with a model of direct service, which is typically called "liaison." Both processes and terms are often represented in the work designated "psychiatric consultation/liaison." Termini and Ciechoski utilized Caplan's concept of "theme interference" in understanding the consultee's conceptualization of the clinical problem. They described the consultative process as follows:

The psychiatric mental health clinical nurse specialist in the consultant role is uppermost a patient advocate. Consultation is the process employed in the situation. The consultant's assessment of the behaviors of the patient, family, and staff determines the role functions and relationships. The methodology of planning, providing, and evaluating patient care is the application of scientific problem solving within the consultation process. Consultation as a relationship process emphasizes this problem solving methodology in the resolution of nursing and patient care problems (p. 78).

Increasingly in the mid-1970s and onward, papers from psychiatric liaison nurses reflected interest in the role, functions, and abbreviated descriptions of complex cases. An excellent paper by Smith (1981) discussed by Kohnke (1981) recalled Marcus's earlier concern with leaving responsibility for the client with the consultee. Smith, the consultant, was called by the head nurse on a surgical unit to consult around an issue where the wife of a recent surgical patient died unexpectedly. The physician and family did not want the patient informed. The consultant, shifting from her classical role to that of patient advocate, intervened and influenced the principals to act. Responsibility was effectively taken away from the consultee. The problem grew into several issues which rapidly escalated. In the final scenarios it was not possible to delineate the original issues from ensuing ones, nor their origins. Kohnke (1981) wrote an excellent, sensitive analysis of the situation, pointing out the various process errors that had occurred and how they might otherwise have been managed.

A rather unusual report by von Shilling (1982) reflects the increasing sophistication evident in nursing consultation. The actual problem required aspects of program-centered consultation as well as consultee-centered consultation. The task was to prepare teams of workers to implement a treatment approach at the children's unit of the Max Planck Institute for Psychiatry in Munich, Germany. Four multidisciplinary treatment teams had to evolve into effective collaborative groups. Von Shilling noted the

necessity of preventing dependence and the development of "self-reliant functioning by mobilization of internal and external resources in dealing with confrontations and change efforts" (p. 73). In this particular instance the institute also employed a "process-resource person" who would remain available to each of the four teams after von Shilling's departure. The author consulted with all the teams and their members individually, but also with the resource person who would continue to guide the group process.

Research Contributions

A review of the literature in mental health nursing consultation uncovered little research in this area. Wolff (1978) and Davis and Nelson (1980) analyzed the nature of their consultation requests. Davis and Nelson concluded from a content analysis of their requests that the character of referrals had altered over a 42-month period in the direction of greater specificity, sophistication, focus, and involvement of the consultant. They theorized that the nurses initiating consultation requests had learned to manage less complex patient situations.

Wolff, examining the reasons for nurse-to-nurse referral, found that multiple factors contributed to the nurse's decision to request consultation. Staff nurses were more likely to refer patients who exhibited the following behaviors: complaining, tense, overdramatizing, demanding, irritable, or angry. They also requested consultation on patients who were withdrawn, worried, depressed, suicidal, manipulative, or dependent, as well as in cases where there was a need for family support. As important as the patient's behavior in triggering the decision to consult was the nurse's reaction to the referred patient's behavior. The finding that a nurse's reactions differed significantly toward referred and nonreferred patients was deemed important. Wolff reported:

A multitude of factors contributed to the nurse's decision to refer a patient to a psychiatric nurse consultant. Those patients who were referred tended to exhibit more psychopathology and to evoke more negative reactions in the nurse than did patients who were not referred.

More importantly, the results indicated that the observation, not the nurses' reactions, was the most significant factor in referral. . . . The nurse's assessment of the patient was critical to the decision to refer (1978, p. 45).

Bryant (1983) also investigated an aspect of the consultative process. Though she was interested in developing a format to evaluate the effectiveness of the psychiatric liaison nurse, she generated data that supported some of Wolff's findings. Bryant utilized a content analysis of 50 sequential consultations over a 3-month period, categorizing these data, in part, through Wolff's patient-behavior groupings. Bryant supported Wolff's finding that depressed patients were those most frequently referred. Bryant also found that followup on recommendations was most often documented for depressed patients and least likely for manipulative and demanding ones. She discussed implications of this finding, suggesting that the consultees were uncomfortable setting limits on behavior and that they probably defended against their own anxiety by withdrawing from offensive patients. Bryant demonstrated that the psychiatric liaison nurse was perceived as effective in the practice setting and that the sample of consultees wished for greater support through formal inservice programs.

Deloughery et al. (1972) investigated the effectiveness of mental health nursing consultation within a general hospital setting. Specifically, her group looked at an attempt to improve the problem-solving ability of hospital-based nurses. The authors utilized group discussion of problem-solving efforts to bring about a desired outcome. Their results indicated that out of nine groups, six showed no change, two showed improvement, and one showed a decrease in problem-solving ability.

Research in mental health nursing consultation is at a very early stage. Both the number of available studies and their design indicate that this aspect of nursing consultation is at the preliminary data-gathering stage. With the exception of Deloughery et al. (1972), all those studies reported are descriptive in nature. The findings are not generalizable nor are they ready for more rigorous analysis. Research in mental health nursing consultation is rare. It will likely remain so in the foreseeable future because relatively few nurses consult; among the small group that do, even fewer are interested in researching their area of endeavor. The pool of trained nurse researchers, i.e., doctoral-level nurses, is only about 1 percent of the entire U.S. nursing population. The majority of that group is in teaching and administrative positions. They may consult, and they usually conduct research; however, the likelihood of their concentrating their research in the area of consultation is small. This means that significant research in mental health nursing consultation will probably develop very slowly. Another related problem is that instrumentation that is relevant to this area is practically nonexistent. To develop the latter is time-consuming. Efforts in that direction must precede reliable outcome studies.

Issues in Mental Health Nursing Consultation

All the sources cited in this paper indicate that consultants should be experts in their area and should have skills in helping others to solve a problem as it relates to the consultant's area of expertise. The achievement of expertise and its acknowledgment by others in the nursing community depend on agreement within the work group about the meaning and measurement of content area skills in which one purports to be an expert. There are wide variations in nurses' levels of expertise, their awareness of other nurses' expertise, and even awareness of standards as described by the American Nurses' Association (ANA) and the standards of specialty practice tested by that association (Fitzpatrick 1983a). At this time there is no credentialing process for nurse consultants, although there is an opportunity for certification of psychiatric/mental health nurses. The latter may sit for either generalist or specialist examinations, depending on whether they hold a master's degree and the number of hours they have had of supervised practice.

At present, formal acknowledgment of a mental health consultant's expertise is most readily observable through ANA certification as a clinical specialist (C.S.). Successfully passing the examination, acquisition of the required hours of supervised practice, and positive references ensure a high level of clinical expertise; it does not, however, indicate that the candidate has acquired a similar level of sophistication about the consultative process. Related to this issue of who is actually prepared to consult is recognition of that expertise. The consumer can make a reasonably sound choice based on certification and experience and work references. Sometimes the peer group does not do this. Polk (1980) theorizes that the difficulty lies in recognition and utilization of a female as an expert:

The female prescriptions, however, encourage (a) a reluctance to recognize and accept one's expertise outside of the mothering and housewife role, (b) difficulty in establishing peer relationships with males, (c) difficulty in directly presenting and accepting responsibility for one's ideas and decisions, (d) difficulty in being assertive and task oriented, and (e) difficulty in being thinking, rather than emotion oriented (p. 35).

These ascribed attributes of the female are in direct conflict with the role functions and attributes of the consultant, namely, being assertive, thinking, peer-oriented, and responsible for one's actions. If Polk is correct, then not only can we empathize with the difficulties of the practitioner aspiring to recognition as an expert, but with the majority of those in the nursing profession

who are female and who, because of their socialization, may not be ready to acknowledge a different role set in other women.

Process issues are also evident in mental health nursing consultation. As mentioned earlier, a wide divergence of philosophies, objectives, expertise, and capacity (or inclination) to evaluate services rendered by the nurse consultant places this role in jeopardy. Because of the paucity of programs for professional development, there is little uniformity of practice standards. Process errors--such as making an incorrect diagnosis of the problem, or mixing consultation, supervision, and psychotherapy--may result in chaos, which the consultant without the needed skills, sophistication, or authority could find difficult (see Kohnke 1981 and Smith 1981). Wrongly identifying the problem or the goal of the consultee may result in a long-term supervisory experience in which appropriate overriding issues of altering practices and expanding conceptualization skills are sacrificed to the shorter-term objective of increasing a consultee's skill in an immediate situation that may not be generalizable to future concerns.

Finally, research and evaluation present problems. As indicated earlier, there is a dearth of reports on mental health nursing consultation. Among those reviewed for purposes of this paper, only five were research endeavors. According to Mannino and Shore (1979), research is necessary to compare different methods of consultation, to compare consultation with other forms of intervention, to clarify the process variables, to relate the latter to outcomes, and to investigate characteristics that describe effective consultants and consultees. From these data will be extrapolated the general principles of consultation. It is also necessary to research outcome measures to determine effectiveness.

Mannino and Shore (1971) wrote that research in mental health consultation takes place in two stages. Initially the problems are directly related to practice, and efforts are made to tie that practice to some new theoretical views:

There is a great amount of discussion and clarification of what is done, leading to the development of scientifically oriented clinical evaluations. Second, an effort is made to begin to structure what is done much more carefully and to evaluate the activity in an objective fashion, integrating ideas from anecdotal material and case studies. This scientific orientation then leads to more sophisticated efforts at trying to understand the phenomenon and link it more solidly to

empirical foundations. Hypotheses are tested through experimentation with the use of control and comparison groups (p. 49).

If mental health nursing is to take advantage of the expertise within its ranks and to understand its goals as they relate to maintenance of mental health, prevention of mental illness, and training and development of its practitioners, it is incumbent on expert consultant practitioners to undertake the aforementioned research mission. It is only through examination of field work that consultation in mental health nursing will evolve into a science. Such is the mission of a profession.

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B. Public Health-Community Perspective

Lucy Ann Howard, R.N., M.S.

Introduction

The purpose of this paper is to discuss mental health consultation from a community mental health/public health perspective. It will include an historical overview, examine current practice, and conclude with comments on problems and issues that bear on future growth and direction.

The scope of community mental health/public health nursing practice has expanded markedly in the last century as nurses continue to assume significant roles in the areas of prevention, intervention, and rehabilitation. Nursing activities in the area of prevention are often characterized as indirect service roles. Consultation is a primary indirect service role for the community mental health/public health nurse. The goal of this consultation role is to influence and improve the quality and range of nursing and mental health services available to individuals, families, and groups within their institutional and community settings.

Historical Background

Consultation in nursing has a long history which has not always been documented nor disseminated in a formal manner to make it readily available to the profession at large. As early as 1859, Florence Nightingale was recognized as a consultant in hospital development and disease prevention, as well as in nursing education (Dolan et al. 1983).

In 1926, the Providence District Nursing Service added a mental hygiene nursing service, describing it as "filling a need for advice and help for staff nurses, arousing interest in mental hygiene as a public health problem and furnishing services gratuitously to workers of other agencies" (Coe 1926, p. 114). By 1939, 20 agencies employed mental hygiene consultants. On the basis of a study of these agencies, experiences with other types of consultants in public health nursing, and at the request of their membership, the National Organization of Public Health Nursing (NOPHN) began to study the mental hygiene nurse consultant. In 1947, NOPHN formed a Committee on Mental Hygiene to develop standards for the preparation required and functions included in the nursing consultant role. The functions identified by that committee include (1) assisting public health nurses to use,

develop, and coordinate community resources for psychological and psychiatric problems; (2) improving knowledge of human behavior so as to increase the productivity of nursing contacts with patients; (3) enhancing the ability to understand attitudes involved in the nurse-patient relationship and methods of work; and (4) strengthening nursing curriculums and practice by integrating applicable psychological concepts into nursing services for all age groups in all settings (Connor 1947).

Consultation was formally recognized as a specialty of nursing and was included in the basic curriculum--the only one of the mental health professions (psychiatry, psychology, social work, and nursing) to have done so at such an early date (Erickson 1966). Qualifications for nurse consultants recommended in 1950 by NOPHN were based on academic and experiential criteria, but also emphasized such personal qualities as ability to work constructively with others, flexibility, sound judgment, ability to share responsibility, integrity, enthusiasm, and sensitivity which can be used for the benefit of others (NOPHN Mental Hygiene Committee 1950).

Ruth Gilbert, in 1960, defined consultation as work-centered problem solving in which the consultant and consultee share their knowledge, skills, and experience, with the consultee free to make plans and take action as he or she may choose (Gilbert 1960). These elements, in many instances only slightly modified, can be found in definitions and practice criteria currently utilized by other professions.

In the 1960s, there was considerable interest in demonstrating the effectiveness of the consultation process and increasing the body of knowledge (Shortal 1961; Van Horne 1964). This emphasis was due in part to (1) the desire of professionals to demonstrate the effectiveness of their programs; (2) the acceptance of critical evaluation as a recognized part of practice; (3) the availability of funds and development of the technology to conduct evaluation studies, and (4) the concern that services should be provided to the largest and most appropriate groups (MacMahon et al 1961).

Although the American Nurses' Association already had developed a Statement of Functions, Standards, and Qualifications for Consultants in Practice (American Nurses' Association 1958), a further Statement on Psychiatric and Mental Health Nursing Practice was developed to increase the understanding and fuller utilization of the nurses' orientations and competencies. This statement cited consultation as one of the indirect nursing care roles. Consultation was expected to influence services available to individuals, families, and groups within institutional and

community living systems and was directed toward, not only nursing educators and practitioners, but other professions, consumer groups, and agencies at all levels as well (American Nurses' Association 1976).

Francis Adamson, an early mental health consultant in community mental health, urged nurses to be prepared to shift emphasis from direct care to that of providing indirect service through assistance to the helping person and to community caretakers (Adamson 1970). Utilizing an experiential description of consultation, Catherine Norris focused on the excitement and flexibility inherent in the multiple roles of "idea person, facilitator, encourager, negotiator, arbitrator, and challenger" without minimizing the demands of this type of practice. The freedom of the consultee to "sample, think about, accept, or reject" the consultant's intervention was viewed as a nonthreatening, flexible way to improve or expand nursing practice (Norris 1977, p. 761). Deloughery and her colleagues challenged nursing to take a leadership role in conceptualizing and articulating theoretical bases for consultation (Deloughery et al. 1971). They also encouraged a critical look at the activities, outcomes, and effectiveness of the consultation process with the goal of moving the impetus to practice from a belief system to a research base (Deloughery et al. 1972).

The evolution and growth of mental health consultation during the 1960s and 1970s were strongly influenced by Public Law 88-64 (the Community Mental Health Centers Act of 1963). During that time, approximately 800 community mental health centers (CMHCs) were established as comprehensive, community-based mental health delivery systems. Mental health consultation and education were identified as a primary and required component of the delivery system. Consultation services to community systems such as schools, hospitals, social services, and law enforcement agencies were mandated to assist agency staff to address the mental health dimension of their work. A limited number of professionals were available to staff the CMHCs during this time of rapid growth, providing an opportunity for nursing to become more visible as a profession which provides consultation services. The traditional role of the caretaker, usually under the direction of the discipline of medicine and located in institutional settings, was replaced by a collegial position as caregiver and independent consultant based in a community setting; also, the demographic characteristics of the setting and the availability of other professionals played a major role in defining the parameters of the nurse's role (Lehmann 1983; Clemence 1984).

Psychiatrist Gerald Caplan, a pioneer in mental health consultation during the late 1940s and 1950s, was a major

influence in nursing consultation. His contributions to the entire consultation field were numerous, but particularly so in relation to nursing. He was active with nurses in developing consultation contracts, conducting research, and encouraging nursing to establish itself as a major force in community mental health, particularly in providing consultation to those systems to which nursing had greater access than did the other professions (G. Caplan, personal communication, 1968).

Consultation liaison nursing, a parallel development to consultation psychiatry, also became more visible during the late 1950s and early 1960s. Duke University Medical Center pioneered a nursing consultation service staffed by psychiatric consultant-liaison nurses who assisted staff on medical and surgical units to respond to patients' emotional concerns but did not assume direct responsibility for providing nursing services (Johnson 1963).

By the early 1970s, a few universities recognized liaison nursing as a subspecialty, including it in their graduate nursing programs (Lewis and Levy 1982). Nelson and Schelke saw the role of liaison nurses as including multiple functions in addition to consultation--such as teaching through case conferences, serving as a role model, and providing specialized direct services (Nelson and Schelke 1976). Liaison work occurred most frequently in medical or health care systems, and the practice environment may have influenced the inclusion of direct nursing functions.

A review of nursing texts, both for advanced practice students and undergraduate students, shows increased attention to indirect practice as a desirable nursing role in the expanded work environment for nurses. The fields of community health nursing and psychiatric mental health nursing have actively encouraged future practitioners to consider careers in the specialties of mental health consultation, liaison, or community mental health nursing. Increased attention has been paid to role functions, development, and preparation of consultations in the theory and process of consultation and its potential as a change strategy (Lancaster and Lancaster 1982; Stuart and Sundeen 1983; Beck et al. 1984; Schoolcraft 1984; Stanhope and Alford 1984; Critchley and Maurin 1985).

The Current Scene

Consultation in nursing continues to be addressed in the literature by practitioners, but with more focus on the conflicts and ambiguities than on the collaborations and clarifications. This uneven emphasis does not convey the support that does exist

for consultation as a legitimate role for nurses, particularly outside of the profession.

System-level interventions are provided by nurses in community mental health centers and to diverse community groups such as parent-teacher associations, church organizations, neighborhood block clubs, and senior citizens councils. The major social systems such as law enforcement, social services, education, health, and government tend to seek consultation around specific issues such as the mentally ill offender, the disruptive client, the suicidal teenager and the noncompliant family; however, they are generally less responsive to systemwide intervention by nurses for program or administrative consultation. This does not seem to be linked to a negative response to consultation but rather to the retrenchment experienced by all public agencies. Frequent reference is made to "the good old days" when there were time, resources, and sanction for interagency consultation.

The area of indirect roles is addressed in curricula, often being incorporated in courses focusing on planned change, organizational dynamics, leadership, management, and role strategies. While these areas are very relevant and closely related to the practice of consultation, a specific didactic course and field experience in consultation is still preferable. Proportionately, more time and emphasis is still devoted to acquiring knowledge and skills which can be viewed as "doing for" rather than "doing with" which is implicit in the definition of consultation. This may be changing, particularly with the increasing influence of the holistic health movement where the primary goal involves working with individuals concerning their health and the ways they choose to preserve it. Therefore, the particular knowledge and skills of nursing would be readily perceived as valuable and useful by another professional or system without a decrease in job satisfaction, an increase in role confusion, or lower status experienced by the nurse.

The level of preparation expected in order to function as a consultant is generally perceived as the master's-level, with the assumption that extensive or specialized clinical experience is necessary before the role of consultant should be publicly claimed. However, some data demonstrate that nurses without advanced preparation, practicing in community settings, have developed an area of acknowledged expertise and are functioning as consultants. Bass's review of consultation and education in federally funded community mental health centers found nurses played an important role in the delivery of this service, providing 6.8 percent of all consultation and education services and spending 3.2 percent of their time in this area. Nurses with bachelor's-

level preparation or below accounted for the largest segment of nursing consultation, but the master's-level nurses, who were fewer in number, spent a larger portion of their work time in such activities (Bass 1974). Perlmutter and Vayda, in a study of 43 community mental health centers, found that 9.2 percent of nurse consultants were at the bachelor's-level, and only 1.5 percent had master's degrees (Perlmutter and Vayda 1974). In a more recent study of consultation and education activities in community mental health programs, Backer et al. found nurses performing consultation and education activities on a regular basis and also serving as directors of consultation and education programs (Backer et al. 1983).

Such areas as assessment of community needs, development of service delivery to special populations (such as battered women), or working with individuals with special needs (such as young pregnant substance abusers) have been identified as areas in which nurses have expertise. Nurse practitioners become well known and are sought out by others for consultation without being formally labeled as consultants.

The emphasis on raising the status of the profession of nursing and defining what is unique to nursing practice may not facilitate the allotment of time and resources needed at the present time to support consultation as a major role for nursing. However, this could contribute to a more solid foundation upon which to build such a role in the future, increase the possibility of consultation with other professions, and establish it as a primary function of nursing. This is particularly so in view of the growing perception that mental health disorders and social problems will increase, but few additional resources will be allocated to directly confront them. Clearly delineated professional parameters could lead to increasing conflict with other professions but can also be viewed positively as a step toward increasing collaborative activities.

The American Nurses' Association is steadily moving toward certification of practitioners as a way of ensuring that the standards of the profession are being met. This could be one means of stimulating the increased utilization of consultation by including it as a major focus or, preferably, as a separate area in which certification is available--as is the case with administration in psychiatric-mental health nursing. Certification could respond to the issue of qualifications within the profession as well as increase the visibility of nurses as mental health consultants among other professions and delivery systems which do not employ nurses. Providing continuing education credit programs with a dual focus on utilization and provision of consultation also could contribute to a renaissance for mental health consultation since it

is clear that consumers and their preferences have always influenced the marketplace.

Community mental health consultation in community settings shares a great deal with liaison nursing, ranging from ideology and theoretical assumptions to practice modalities. It is differentiated in a broad sense because of a focus on the community, the system, or the group, rather than individuals. Prevention of disorder and maintenance and enhancement of function, rather than remediation or treatment of individuals or groups already identified as disordered, is its primary goal (Lancaster and Lancaster 1983). There seems to be a strain between community mental health consultation and psychiatric consultant-liaison reflecting either a struggle for dominance or lack of definitional clarity. The liaison nurse continues to serve the primary function of improving direct patient care and assisting staff to improve their ability to deliver holistic health care in a practical and economical manner. The practice settings are usually health care systems such as acute care general hospitals, ambulatory health care centers, and nursing homes but are also beginning to include non-health-related organizations such as schools and industries (Lehmann 1983). The community mental health consultant may practice as a part of a team, maintain regular contact, and provide problem definition. However, most of these consultants work alone, under the terms of a consultation contract, and have direct contact with the client population only under clearly defined and negotiated circumstances.

Although there are considerable overlapping and sharing between the two perspectives, the differences, particularly in regard to role functions and primary goals, seem to generate some amount of tension. This tension probably reflects a lack of definitional clarity due to separate and distinct, but interdependent activities, though at times there is also a suggestion of dominance struggle. Reference is also made to the commonalities, collaboration, and cooperation between the two perspectives (Lehmann 1983; Simmons 1985).

Community mental health centers may not now be as receptive as they were in the past to mental health consultants of any discipline. Faced with decreased funding for developing additional centers or expanding programming, the focus has reverted from prevention and indirect service to treatment and direct service, with emphasis on revenue generation and self-sufficiency. The need to demonstrate cost-efficiency, as well as program effectiveness, in addition to mandates to serve the needs of particular populations (such as the long-term severely impaired, the deinstitutionalized, and the homeless) have taxed the resources and capacity of most of the service delivery systems.

These factors, plus the change in the nature and distribution of mental health resources, have caused a major redirection of the primary mission and goals of most centers. Roles for mental health professionals are being viewed in a more restricted and traditional manner, oriented to licensing and credentialing and influenced by the requirements of the reimbursement systems. Thus, nurses may be recruited to provide direct service such as to staff medication clinics, manage the milieu in day treatment or partial hospitalization programs, or perform health assessments rather than fill indirect service roles. Consultation is still sanctioned and supported, but does not have as high a priority as it once had.

A recent report about consulting on services to the chronically mentally ill clearly indicates there is support for consultation in the interest of this high-risk population. Programs described include consultation to human services agencies, local government, business, employment and training agencies, media, advocacy groups, natural support systems, and educational institutions. Nurses should be well qualified to fill this role, particularly if their clinical practicum includes work with this group in either an institutional, residential, or community setting. This focus can be stimulating to the consultant particularly if efforts result in cost-effective approaches to serving the group, generation of revenue through charging a fee for consultation services, and the development of community support for such programming (Backer et al. 1984).

Community mental health nurses report that if their organization allocates even a part of their time to consultation, they continue to work with consultees in public health departments, nursing homes, religious organizations, employee assistance programs, day care centers, and primary health care service sites. They consult in a wide range of settings including emergency rooms, speciality units in hospitals, adult education systems, grass roots organizations, and private practice offices.

Future Directions

Albee has called for a major change in the approach to delivery of mental health services in order to meet current and future needs. That is, although a larger number of mental health professionals are being educated today, the demand for services seems to be growing even faster (Albee 1980). In particular, while psychiatric mental health nursing practitioners are growing in number, the rate of increase is slow. Recruitment of students for graduate programs is encountering difficulty because of the high cost of education, the decline in financial support, and a

perceived decrease in the number of remunerative and interesting employment opportunities for advanced practitioners.

Meanwhile, public mental health systems continue to experience problems in recruiting and retaining qualified staff. If this trend continues, it should increase the need for mental health consultation in order to make available the skills of highly trained practitioners to a larger number of clients rather than struggling to provide direct services with limited numbers of professionals. Continued reliance on traditional, one-to-one approaches, even when supplemented by effective group modalities or early and brief intervention, will have to change. Mental health consultation, with its potential for prevention, increasing quality of service, and efficiency in delivering indirect service may represent a viable and reasonable alternative for psychiatric mental health nursing. If such a choice were made, it would require targeted efforts, including adding or strengthening consultation courses in the curriculum; refining and evaluating present theoretical models; improving the range and type of field experience; supporting research, particularly on the effectiveness of consultation; and increasing the number and visibility of academic and practitioner role models.

Current changes in the health care delivery system, especially in regulations related to the type and amount of services provided in institutional settings, may support the choice for nursing of either community mental health or psychiatric-liaison consultation. That is, the liaison role could serve the primary function of improving direct patient care in medical settings and assisting staff to increase their ability to deliver holistic health care in an efficient and effective manner. The community mental health consultant role could focus on providing a similar service to community-based settings such as nursing homes, extended care facilities, home care nursing services, and other systems and groups within an individual client's life space. Commonalities rather than differences between the roles should be emphasized. Ways to actively collaborate should be explored with the focus on improving the service delivery system for the consumer, particularly at the point of transaction from the institution to the community. Consideration can also be given to extending the definition of both roles to include meeting clients' psychological needs (Lehmann 1983), providing prevention management (Hackett and Cassem 1978), and facilitating relationships (Lewis and Levy 1982).

The growth of the self-help or support group approach may also be supportive of consultation. It aims to restore, maintain, or promote mental health, based on the premise that individuals are responsible for their health status and using contracts with the provider to facilitate achievement of personal goals.

Consumers have come together to increase their individual ability to cope with the stress of retirement; infertility; caring for a dependent family member; a major life change in health, occupation, family, or personal status; or posttrauma recovery. Nurses have participated actively in the development of these groups by providing consultation services. The services are generally requested because of an individual nurse's recognized competency and expertise in the area of the particular stressful event or crisis rather than because of professional membership or model of consultation utilized.

The increased amount of interest and activity in responding to the needs of the severely impaired has, in some instances, raised the awareness of communities of gaps in services and the need for increased resources. It also has had the sometimes undesirable effect of advocating more restrictive and more economic service delivery systems. Whether consultation will continue to be seen as one of the potential solutions to the shortage of skilled mental health personnel to work with this population and to address the community concerns they generate is an open question.

The history of mental health consultation has demonstrated that nontraditional personnel can be utilized to deliver mental health services; roles previously defined as the domain of a single profession can be shared; and more people can be reached by indirect rather than direct modes of services. However, current and future reimbursement requirements may wipe out these gains by specifying as reimbursable only direct services delivered by credentialed staff at approved sites with observable behavioral outcomes. Mental health centers probably will not be as willing to use their limited consultation resources to build and maintain the competence of others unless a tradeoff or compensation is to be received. Requests from systems which are unable to provide reimbursement or consumer-initiated programs for individuals not at risk will be responded to slowly and reluctantly. Law enforcement, church-related, health, and social services systems which have demonstrated their ability to serve the severely impaired population may need and request consultation, but it will only be provided when there is no other alternative.

The introduction of client services management, with its emphasis on accountability, comprehensiveness, and continuity of service, may support the increased utilization of mental health consultation because of its emphasis on system advocacy and consultation. It is not a direct service, but it has achieved wide acceptance and in some areas has been considered an essential service element, worthy of adequate public financial support. This may pave the way for reimbursement systems to include

consultation as a service which should be funded, even if calculated as part of overhead or operating costs, since its major focus is improving the community and natural support system. When effective, these efforts can assist in decreasing the need for treatment services.

Issues and problems in the overall field of mental health consultation also have impeded the evolution of this consultant role in nursing. Polk commented that the profession socialized students to believe in general, omnipotent knowledge, so a nurse is expected to know everything, without discriminating between degree and area of expertise. To seek help, therefore, by utilizing a visible mode such as consultation may be perceived as a sign of inadequacy and a lack of accountability (Polk 1980). Some consultation models (e.g., Caplan 1970) place unintended emphasis on a deficit by describing the reasons for consultation as a lack of knowledge, skill, confidence, or objectivity. Therefore, it is a natural conclusion that consultation is to be sought only for a crisis or a problem. If nursing were to concentrate on a more positive orientation to consultation--as a means to increase knowledge, build confidence, and promote growth--this limitation would be minimized, and the value esteemed by nursing that professional and personal growth improve practice would be maximized.

Socialization of nurses as consultants or consultees can begin during their educational program by developing group or individual consultation experiences in their clinical practicum, exploring and discussing anxieties associated with assuming nontraditional roles in seminars, and inviting established consultants to guest lecture (Polk 1980).

Concerns about process issues, gender issues, and lack of theoretical models may introduce too much caution in an attempt to avoid criticism from within and without the profession. Indeed, the development of the nursing role of psychotherapist faced some of the same concerns. Rather than have their role enlargement impeded, nurses who were eager to provide therapy, despite the lack of support within the mainstream of the profession, sought supervision from experienced therapists. They carefully analyzed their practice for effectiveness and increased their theoretical knowledge through reading, continuing education programs, professional conferences, and networking. Nurses who want to be consultants could adopt a similar approach.

Many consultants, well regarded today in community mental health, developed their skills through trial and error and on-the-job apprenticeship, supplemented by self-directed study and formal training when it was available. Therefore, it may not be

necessary to impose additional requirements, other than entry-level professional qualifications, substantiated expertise, and credibility for nurses who wish to avail themselves of an opportunity to practice mental health consultation. There is a market for mental health nurse consultants in the community. Many rural mental health centers have turned to consultation as a primary service modality because of the scarcity of professional resources to deliver direct services. Some urban and suburban centers cannot attract or retain nurses with advanced preparation because their salary scales cannot recognize additional education, experience, or expertise.

The issue of the appropriate level of preparation is not an easy one to resolve. For example, a bachelor's-level nurse who has devoted many years to working with a particular population, is knowledgeable about the demographics and dynamics of the community, has earned the respect of other professionals, and has been exposed to the practice of mental health consultation may be a particularly effective consultant to a system which deals with that population. In contrast, a nurse with doctoral preparation, courses in consultation, limited experience with the population, and no personal knowledge of the community or contacts with the mental health delivery system may not be as effective. A team approach would be optimal, wherein the nurse with advanced preparation would assist the primary consultant by providing peer supervision, developing an evaluation design, or identifying research opportunities in the consultation process.

The concerns about sufficient expertise and knowledge are valid, but the value of consultation should be judged by the outcome rather than the fee received for services, the reputation of the consultant, or the formality of the contract. If the nurse has a recognized area of expertise and knowledge and is interested in or expected to function as a consultant, professional development can be accomplished. Resources such as inservice presentations, training manuals, videotape training modules, teaming, group supervision, and peer networks are a few of the methods available to maintain and improve quality of practice.

Nursing, as a field, has not done much research in the area of consultation; at least seven doctoral dissertations completed between 1955 and 1981 have dealt with nursing and consultation (Mannino and Shore 1983). Serious consideration should be given to collaboration with other professionals in the conduct of research if the resources available in nursing continue to be limited. Because the nursing profession has been the recipient of consultation from other professionals, there is a wealth of information which has not been explored concerning the process of consultation itself. Nursing could assist the consultation field in

the definition of the effectiveness of consultation on practice, the differential impact of various consultation models, the influence of the consultant's personal characteristics, and the duration of the effects of consultation.

Until the situation changes in community mental health centers or the decisionmakers propose a radical revision in the delivery of health care, mental health consultation in psychiatric mental health nursing will continue to be regarded as a subspecialty or adjunct role. Economic necessity will dictate that only those nurses who incorporate as a private provider organization or enlarge their role to include collaboration in the implementation of program developments (Baker 1982) will be able to maintain a primary or full-time role as a mental health consultant.

Consultation will continue to be a critical component of nursing practice. The rapid expansion of knowledge demands the use of consultation within the profession to locate information and facilitate its utilization. Continually diminishing health dollars and the focus on fiscal accountability dictate the development of cost-effective, innovative, and marketable services. Consultation will be invaluable in this effort.

Nursing needs to become a more visible and powerful influence in legislative processes, modification of health care financing models, and the distribution of health resources. Without such activity, mental health consultation in nursing will likely be relegated to a sphere of minor influence, and psychiatric mental health nursing will continue to "do for with less." Demonstrating the contribution and impact on services of diverse nursing roles--of which consultation is a major one--would help launch psychiatric mental health nursing into a new era of independent practice with satisfactory remuneration and adequate recognition.

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CHAPTER 7

THE ROLE OF SOCIAL WORK IN CONSULTATION

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Consultation as a modality of intervention in the human services has been widely discussed but frequently poorly understood. There is still much confusion about what consultation is, who does it, what problems are potentially solvable through consultation and what its objectives should be. Despite this, all the major helping professions are engaged in it and now, quite appropriately, consider consultation a special area of expertise. This volume is itself testimony to the interest consultation has aroused in all the professions. This chapter is about social workers as consultants to other social workers and to helping professionals and paraprofessionals in other disciplines. It is intended to cover aspects of what is special about consultation in social work. Emphasis is on putting consultation in social work in historical and contemporary contexts, outlining its basic elements, reviewing the fields of human services in which social work consultants are active, and identifying issues and problems that remain to be solved if the potential for consultation is to be fully realized.

Consultation Defined

Consultation, in this article, is viewed as an interactional helping process. It is seen as consisting of a series of sequential steps taken in the context of an interpersonal relationship to achieve some objective (Kadushin 1977, p. 25). What makes the consultant role in social work unique is that it embodies the values, knowledges, purposes, and objectives of the social work profession (see Bartlett 1958, pp. 3-9; and NASW 1981, p. 6). Another feature that characterizes the consultant role is the social component inherent in social work--that of providing links between individuals' needs and those social arrangements designed to meet those needs, primarily attained by helping people to understand, utilize, and change social institutions. Methods of intervention may include work with individuals, groups, organizations, and communities covering a wide variety of problems and situations (Specht 1972).

For the purposes of this chapter, consultation is further defined as a formal process and not as the kind of informal interchange that is common among colleagues. In the formal

process of consultation, the social worker with an identified area of expertise attempts to help another professional or paraprofessional find solutions to an identified problem, the total responsibility for the eventual decision being left to the consultee. It follows from this, also, that consultation is seen as a problem-solving process. Its context is a voluntary relationship where the consultant and the recipients of the consultation share in solving a current work problem. The outcome of the relationship should also be that future problems of a similar nature would probably be handled more sensitively and skillfully (Meyers et al. 1979, p. 4).

Evolution of Consultation in Social Work

The beginning of the profession of social work is generally traced to the founding of the first U.S. charity organization societies (COSs) and settlement houses. Both occurred in the late 1870s and 1880s. Consultation in social work also dates back to that time although there is controversy about how it began. Much of the controversy relates to confusion about what differentiates supervision from consultation. If consultation is defined as a voluntary relationship where the consultant is not administratively accountable for the consultee's performance, then consultation would have been one of the first major activities in social work. As Kutzik explains, it was the so-called "agents" in the early days of the COS who, representing the agency, in a sense provided consultation to the volunteer "friendly visitors" of the time (Kutzik 1977). These visitors, often society ladies, were seen as such models of strength and wisdom that it was unthinkable that they could be "supervised," i.e., held administratively accountable (Kutzik 1977, p. 30). This prototype of consultation was first described as a process where the "agents" would spend all of their time "receiving" the friendly visitors and giving them "information and advice" (Smith 1885, p. 70).

There were four additional major historical landmarks in the evolution of consultation in social work. One relates to the visiting teacher concept that developed out of the settlement house movement around 1906. In their beginning years visiting teachers were actually employed by settlement houses and carried out a variety of tasks in the schools which included work with curriculum development, organizational issues, and methods of teaching (Levine and Levine 1970). In today's terms one might describe them as community-based consultants using a situational approach toward effecting environmental change. A second landmark involved the use of social workers during the 1920s in connection with the early child guidance clinics, to work with teachers, social agency staff, court personnel, and others in the community with a focus on changing the environment to make a more healthy place

for the child to live (Witmer 1940). Another landmark in the evolution of social work consultation occurred in the field of public welfare during the 1930s. Staff-level workers with specialized expertise were made available to help line staff to upgrade their skills and performance so as to increase the quality of service to clientele (Taschman and Mannino 1962). One final landmark relates to the early practice of medical social workers in the 1940s where consultation was provided to hospital administrators, community agencies, and medical personnel to help improve their understanding of the psychosocial aspects of illness and medical care (White 1947).

Of particular interest in this historical perspective was the clear use of the social worker in the role of consultant during the early part of the century when their main expertise centered around social issues and the primary emphasis was on changing environmental conditions. This began to change in the 1930s when social workers, trying to establish a knowledge base, came increasingly under the influence of other professions. For example, there was much concern about how psychiatrists could advance the psychodynamic understanding of caseworkers, as illustrated by a number of Family Service Association of America publications (1953, 1956), and social scientists were even hired as regular consultants to social agencies (see Pollak 1956). Consequently, social workers saw themselves primarily as recipients of consultation, not as its providers. This began to change with publication of a volume on consultation in social work practice written and edited by Rapoport (1963) emphasizing the role of social workers as providers of consultation. In 1965 "consultation" appeared as a subject heading for the first time in the Encyclopedia of Social Work (Rapoport 1965).

The Community Mental Health Centers Act of 1963, which mandated consultation and education as one of the five essential services of these centers, also projected social workers, who were heavily involved in mental health, into the limelight. Initial experiences with consultation in mental health were subsequently adapted to other fields of practice in social work because, used as an additional modality of service, it was found that consultation could increase the competence of less-experienced service personnel, and thereby compensate to some degree for the shortages in skilled professionals (Mannino and Shore 1971, p. 1). Another advantage was that, through consultation, knowledge would be spread to previously inaccessible locations. Among the fields of practice in which there was an influx of social work consultants were schools and health, law enforcement, and public welfare agencies. Later, such newer fields as industry and care for the elderly also benefited from social work consultation. A discussion of these fields follows.

Fields of Service

The growth of consultation in social work has been marked by developments in traditional fields of service for social work consultants and expansion into newer areas. The more traditional fields have included medical social work, school social work, public welfare, the community center field, and the private health and welfare sector such as community health and welfare councils and other community organizations (Rapoport 1977, p. 1943). Newer fields of service now include developments in rural social work, industrial social work, involvement with the courts, military social work, and extensions into newer areas of community mental health such as work with community residential facilities. Consultants have also been prominent as evaluators of social programs, particularly those financed by Federal grants.

As for who the consultees are, the results of Kadushin and Buckman's recent study (1978) on consultation offered by social workers are illuminating. These two researchers obtained the responses of 483 out of 970 members of the National Association of Social Workers who identified their primary job responsibility as consultation. Results indicated that other social workers were by far the most frequent recipients of such consultation. Approximately one-third (35.2 percent) of the contacts of the social work consultants in the preceding year had been with their own professional colleagues, mostly in the traditional social work settings already mentioned. Nurses came next with 15.6 percent of the consultation contacts, followed by teachers with 15.1 percent, doctors with 12 percent, psychologists with 10 percent, and a scattering of contacts with clergymen, lawyers, police, and judges, each accounting for 4 percent of the social workers' consultations.

Traditional Fields of Service

Medical settings. Consultation in relation to the physically ill in hospitals emerged only slowly after the first medical social work department was established in Boston in 1905. The initial focus of medical social workers was on direct service, but as the relationship between physiological and psychological functioning gained greater recognition, the range of social workers' contributions gradually broadened. In fact, Rosenberg and Nitzberg (1980) refer to the current "role expansion" of the hospital clinical social worker and note that consultation is increasingly becoming part of their duties. The consultation includes among other aspects, consultation to physicians and other social workers in other than supervisory situations. The growth of bachelor-level social

work programs in universities also appears to have promoted the use of consultants as newly graduated social workers hired by cost-conscious hospitals were found to be in need of supervision or, at least, of consultation services. Indeed, in many hospitals, practitioners with a master's degree in social work (M.S.W.) are now used less for the rendering of direct services but more to provide consultation to junior workers, combining the roles of administrator, teacher, supervisor, and consultant.

Newer areas in medical social work have also seen the input of social workers both as direct practitioners and as consultants. These areas now include genetic counseling, where consultants are used as "resource specialists" (Hamilton and Noble 1983, p. 22), programs focusing on decisionmaking about birth control (see, for example, Goodman and Hiestand 1982), and rape crisis clinics where social workers provide consultation to police and other professionals (Fox and Scherl 1972). In addition, social work consultants are increasingly having input into the creation of therapeutic environments in particular wards (see, for example, Geist 1977) and even in whole hospitals (see Lerner 1978; and Kornblum and Marshall 1981).

In a recent poll of readers of Health and Social Work, hospital social workers with direct service responsibilities ranked "consultation in health settings" as sixth in importance out of 12 job functions listed, while hospital social work directors ranked it eighth in importance (Kane 1981).

School settings. The first use of social workers in school settings occurred about the same time as their introduction into health settings, about 1905. At that time, private agencies in Boston, Hartford, and New York first financed the employment of social workers who were called "visiting teachers" (Costin 1969a) to help the schools make organizational and curriculum changes. More recently, the role of social workers has primarily been clinical in nature, i.e., providing direct services to individual pupils or their families. The return to a consultation-liaison approach, however, is gradually taking place and a new role is slowly emerging with the social worker increasingly working at the interface between the child, the school, the family, and the community (Costin 1981).

There is some empirical data available which documents a trend in this direction. In 1975 Meares replicated an earlier survey (Costin 1969b) in which a random sample of school social workers were questioned about the importance of a number of tasks in school systems. The findings suggested that school social workers had changed their model of practice from a direct clinical service approach, as found earlier by Costin, to a broader

consultation-liaison model (Meares 1976). Later, a survey of readers of the School Social Work Bulletin revealed that consultation to teachers was a service performed by 87 percent of the respondents (Alderson et al. 1982). Further support for such a shift was found in a Canadian study by Lambert and Mullaly (1982). Thus, there appears to be a clear trend in the direction of an indirect consultation model for school social workers which is more in line with that of the early visiting teacher model.

As yet relatively unexplored is the impact of Public Law 94-142, the Education for All Handicapped Children's Act, which was implemented in 1977 and requires a comprehensive assessment, including a social assessment, for all children being considered for special placement in the school system. The law appears to be having the effect of creating a greater demand for social workers, although until recently there was little or no evidence as to its effects on the school social worker's practice. Recognizing the gap in social work practice in schools, Timberlake et al. (1982) studied the law's impact on a number of school social work practice tasks. They gave a questionnaire containing 21 practice tasks to all of the participants of the 1979 National Conference of School Social Workers. The results showed that consultation was the most frequently performed task for 79.1 percent of the respondents. The three practice tasks that most changed with implementation of Public Law 94-142 were diagnostic assessment, the social case history, and consultation. Hence, these findings suggest that the trend toward a consultation-liaison role for school social workers continues. However, a more traditional practice which relates to direct service delivery also clearly continues to be an important part of the school social worker's role.

Community mental health settings. In mental health settings, considerable attention is devoted to the role of consultants. Nevertheless, as recently as 1981, Ketterer observed that consultation was still one of the least understood of the essential services required of community mental health centers (Ketterer 1981, p. 35). There is the added difficulty of singling out social workers as such in the community mental health movement because the mental health field generally places much emphasis on interdisciplinary collaboration. Nonetheless, there are some data, mostly descriptive, which speak to the service aspects of the social workers' role in community mental health consultation.

First, it is important to note that large numbers of social workers work in community mental health centers. In 1974 an estimated 27,000 social workers were on the staffs of community mental health centers, and in 1976 an estimated 30 percent of all

community mental health center directors were social workers (Kuramoto 1977). Another report in 1974 indicated that social workers provided more consultation in community mental health centers than did consultants from any other discipline, accounting for approximately 25 percent of all consultation (Bass 1974). Hence the service impact of social workers in community mental health centers seems clear.

Additional information relative to the social work consultant's role in community mental health centers comes from a study conducted in 1974-75 of 43 centers located in the Middle Atlantic States, i.e., Delaware, District of Columbia, Virginia, Maryland, West Virginia, and Pennsylvania (Perlmutter and Vayda 1979). Findings from this study revealed that social workers made up 24.8 percent of designated consultation staff and 31.4 percent of ad hoc consultation staff. Also, 24.2 percent of the directors of consultation and education services were social workers. These figures point to the importance of social workers as consultants in community mental health centers.

An important issue in consultation relates to how it is defined by its practitioners, as has been discussed above. Perlmutter and Vayda (1979) analyzed four objectives of consultation and education--i.e., prevention, community education, case consultation, and caretaker training--by the disciplines involved. Social workers, like most of the other disciplines, mentioned community education and caretaker training most frequently. However, social workers were less inclined than their colleagues in psychology or nursing to view prevention as a priority item, and differed from all other professional disciplines in assigning the lowest priority to case consultation. On the other hand, in answer to a question concerned with the feasibility of three types of primary prevention activities in consultation and education practice, social workers (along with psychiatrists) viewed social action as more feasible than did psychologists or nurses; the social workers (together with nurses) also viewed institutional change as more feasible than did the other disciplines. All disciplines ranked quite high the feasibility of crisis intervention. This finding would seem to reflect the social practice orientation of the social worker. But when the various disciplines were asked about their support of specific programs which represented primary, secondary, and tertiary levels of prevention, social workers showed the greatest discrepancy. They were more likely to support secondary and tertiary programs and less likely to support primary programs (Perlmutter and Vayda 1979), which would seem to reflect a tendency towards more traditional practices.

Overall, these data, however, reflect a relatively broad concern for consultation and education, i.e., social action programs together with more traditional secondary and tertiary programs. In other words, mental health consultation as practiced by social workers in community mental health centers is certainly not seen as a means chiefly for implementing primary prevention programs, but rather as a means of implementing a variety of community-oriented programs which function at different levels in the impact they are expected to have.

In community mental health an extremely significant area in recent years has been that of residential care for the mentally ill in the community. Consultants have, for instance, been involved in grantwriting to develop halfway houses, in establishing cooperative apartments for the chronically mentally disabled, and in providing ongoing education and evaluation services for both these types of activities (Goldmeier et al. 1978; and Goldmeier 1980). Social work consultants have also been involved in reaching out into so-called "slum hotels" where many of the formerly institutionalized, whether by design or default, were living (Shapiro 1971).

Long-term care settings. The evolvement of social work services in long-term care facilities, primarily in nursing homes, which house many of the mentally as well as physically impaired, is most instructive in understanding both the use and, perhaps, misuse of social work consultants. Consultants' activities in these settings are well documented in the studies of Austin and Kosberg (1978) and Mercer and Garner (1981), both completed subsequent to the initial stimulus provided by a federally supported study in this area (NASW 1977; Austin 1977). A social worker's presence in nursing homes began with the initial standard-setting intervention of the Federal Government requiring social services in order for a home to qualify for Medicare and Medicaid reimbursements. However, standards on both Federal and State levels were gradually relaxed, prompting much concern in social work circles (see, for example, Knee 1977, p. 9).

This relaxation of standards also had implications for social work consultants. Thus, Mercer and Garner report (1981) that in Arkansas social workers in nursing homes now need only be "designees" if consultation by a professional social worker is provided. A similar situation exists in the State of Maryland. Social work designees in Arkansas and Maryland are not required to have any education or prior experience in social work. Indeed, in the Arkansas study only 2 of the 49 designees sampled reported previous education and experience in social work, 28 percent having been promoted or transferred to their present position from such

positions as aide or housekeeper. Nor surprisingly, then, consultants in nursing homes, as Mercer and Garner report, spend most of their time in reviewing case records, teaching very basic case-work techniques, and assisting in treatment planning, to the virtual exclusion of activities related to process or program consultation.

This limitation might have been more acceptable were it not for the fact that the impact of the consultants, 90 percent of whom had a master's degree in social work (MSW), could at best be only minimal--66 percent meeting with their designees only once a month or quarterly, and 22 percent twice a month, each time for about 2 hours (Mercer and Garner 1981, p. 6). The Mercer and Garner findings, it might be added, further support the earlier findings of Austin and Kosberg in the southeastern United States (Austin and Kosberg 1978, p. 64). The disturbing question raised, of course, constitutes a frequent dilemma for consultants. In view of the infrequent consultative visits and limitations on the part of consultees in applying what is taught, can consultants actually make a meaningful contribution under these circumstances? And, if they serve simply to maintain the illusion of a required social work presence so that the facility qualifies for State and Federal reimbursement, are they allowing themselves to be misused? Or, is any reasonably thought-out social work contribution better than none at all? Perhaps the footholds of both the social work designees and their consultants are useful as springboards for a more responsive social work presence at a later time. The ethical issues stemming from these positions are not inconsequential and answers are not easily forthcoming.

Public welfare settings. Public welfare, particularly child welfare, has been another field where social work consultants have made contributions. In child welfare, there has been special concern about child abuse and protective services. The American Humane Association is particularly prominent in this field and is an example of an organization whose major contribution is rendered almost completely by its consultants. The association, for instance, organizes teams of consultants who lecture and consult with child welfare workers throughout the country. It also publishes manuals and books written by their consultants and used in their work (see, for example, Holder and Mohr 1980). Many of the American Humane Association consultants are based in university settings, as are consultants active in public welfare and mental health. Generally, as such, they are engaged particularly in intellectually oriented contributions to staff, providing guidance in experimental projects or in writing up case studies and manuals (see, for example, Rieman 1982). Developing theoretical approaches to understanding agencies as organizations and

conceptualization of the consultation process are other areas in which these consultants have been active (see Goldmeier 1971).

Emerging Fields of Service

In addition to these more traditional fields in social work consultation, a number of emerging fields illustrate the variety of endeavors in which social work consultants are engaged. Whether these emerging fields actually represent new fields of service is, of course, debatable and depends on how broadly a field of service is defined. However, all appear to have emerged from recent developments in the economic and political climate of the country.

First, there is the extension of social work into new rural communities. Social workers, even in older, established rural areas, have for some time recognized the importance of consultation services complementing and sometimes even preceding clinical services (Walsh 1981; Held 1977). Indeed, Held, a social worker, went so far as to propose that "the use of consultation and education services are prerequisites for, and directly related to, the ability of the mental health program to gain entry and become a vital part of the rural community" (Held 1977, p. 372).

In recent years, as a result of energy exploration, a number of new rural communities have been established or built adjacent to existing communities. It appears that social work consultants are in the forefront in trying to counter the attendant problems of these boom towns. The problems have been depicted as stemming from what two social workers who have studied this phenomenon described as "boom-town bifurcation" (Davenport and Davenport 1981)—i.e., the division of a small rural town into opposing camps of newcomers and old timers. Because of the resulting friction, new and needed services could not be established and the new population could not be integrated. The main activity of consultants in this kind of situation was to act as facilitators in consulting with natural helping networks as a prelude to increased efforts to mobilize formal helping systems (Davenport and Davenport 1982, p. 112).

A second emerging field, industrial social work, reflects increasing pressures in social work to interface with the private sector or with the government as an employer. While the direct-service component of industrial social work has existed for some time, especially in the form of short-term counseling and referral services, consultation has not been highlighted until much more recently. For example, a study of the heavily industrialized Chicago metropolitan area in 1967 notes the existence of counseling services for problems related to alcoholism and money

management but virtually nothing in the area of consultation (Slotkin 1971). Later articles and books on industrial social work do note, however, that consultation to employers is a growing service. One example is the Employee Counseling Service Program of the U.S. Department of Health and Human Services (Masi 1982, p. 213). In that Federal program, social work consultants help management to identify employees with problems. Among other tasks, consultants help evaluate such criteria as excessive absenteeism, both as an area of intervention and as an indicator of even more serious problems.

However, consultation on this level, even though representing an expansion of direct service programs, is still quite limited in the effect on the broader environment. It does not help in improving the interactions between the workers and others in the environment, or in making the workplace more responsive to the needs of the work force. Work being done at the World of Work Program at the Hunter College School of Social Work and the Industrial Social Welfare Center at the Columbia University School of Social Work is contributing significantly to clarifying the role of the social work consultant in industry and identifying the practice issues involved in the consultation process (Kurzman and Akabas 1981). From this work and the work of others has come the notion that assessment, like intervention, must be done within the context of the environment. When the assessment shows that the individual worker is basically sound, but is having difficulty with his job, then the intervention must be carried out within the context of the work environment (Mannino and Shore 1984). Often this is done by modifying difficulties in the transactions which lie at the interface of the worker and the environment.

Quite recently, the outlines of still another specialty, forensic social work, have been pointed out (Whitmer 1983). The forensic social worker deals with such problems as threats of violence or actual violence, as well as such difficult issues as the right to receive or refuse treatment and involuntary confinement. In a San Francisco experiment mentioned by Whitmer (1983, p. 220), the forensic social work consultant advises the court on how it can best use its power to compel social or psychiatric intervention in the interest of the accused, keeping in mind that society must also be protected. However, not all forensic social work is concerned with coercive procedures. For example, a growing number of consultants, not all of them based in social service agencies, advise the courts around custody issues in separation or divorce proceedings (Hoorwitz 1983).

Finally, a development that may or may not qualify as an emerging field of practice is the increasing tendency for social

workers to be engaged in private practice. This feature of social work practice today, to be further discussed later in this chapter, has apparently affected nonclinical activities such as consultation as well. How much consultation is done by this newer group of private practitioners, and where it is done, are questions that have not yet been answered. However, these consultants are bound to have an impact.

Education for Consultation

How do social workers acquire the skills and training to do consultation? It appears that, currently, preparation for consultation in social work is somewhat haphazard. This is certainly the impression gained from Carter and Cazares's brief review of a number of training programs in consultation (1976, p. 11). However, these authors were not specific as to whether the training programs described were under social work auspices or directed at prospective or active social work consultants. Many of the programs they cited were conducted by universities and others by State departments of mental health. These programs tended to be directed at administrators and professionals, such as school psychologists, who were already credentialed. Their survey suggests that, at least at the time the survey was conducted, consultation was thought to be an activity in which trained professionals engage after they have already acquired experience and skill in some other aspect of work in their professions. This, it would appear, is as applicable to social work as it is to the other helping professions.

That education for consultation is acquired largely after graduate school is supported in another survey, this one more germane to social work, which concluded that content for the teaching of consultation in graduate social work education had not as yet been carefully worked out (Smith 1975, p. 104). By 1979, the situation apparently had still not improved. Thus, in a Council on Social Work Education (CSWE) report published in 1979 (Rubin 1979), only West Virginia University appeared to be particularly responsive to the needs for education in consultation. West Virginia University, incidentally, is a school also very much interested in rural social work, an area where consultation is seen as particularly essential. The schools in the CSWE study were the University of Kentucky, West Virginia University, University of Michigan, Florida State University, New York University, Simmons College, and the University of Chicago. All seven schools mentioned consultation as an area of attention, but only in a very general sense with special focus on interagency collaboration. A unique postgraduate-level course specific to mental health consultation has been offered by the University of North Carolina

School of Social Work for a number of years as a 12-month, 30-hour graduate-level course for persons already holding a master's degree in social work. Another training program worth mentioning is the Portland State University School of Social Work's Community Mental Health Training Project. An important contribution from this program has been the development of teaching materials on consultation directed at both graduate-level training and continuing education. Unique among these is a consultation casebook, a rarity in the field. Case material is presented in process stages, introduced by brief theoretical statements and followed by questions designed to stimulate thought and discussion (Collins et al. 1977).

There is no available data about the number of social work consultants who have had training in consultation. Smith surmised that consultants resort to less formal means of preparation (Smith 1975, p. 75) such as learning from supervision, through role modeling, from reading, or from attendance at inservice training sessions.

Apparently one of the most important aspects of the preparation for social work consultation is extensive experience and education in social work. For example, of the 483 respondents in the Kadushin-Buckman (1978) survey of the practice of social work consultation, 95 percent of the respondents had either an M.S.W. or a more advanced degree and had an average of 15 years of paid experience in social work including 10 years of work as a consultant. Yet only 22 percent of these practicing consultants had completed a course in consultation given by a school of social work, and 35 percent had never received any formal training in consultation. A limited number had attended a training session at a special facility, and others had attended national conferences or short workshops or institutes on consultation given by schools or by the agency of employment.

Unfortunately, special courses and educational programs in consultation generally provide little or no information that can be used to judge their success or failure, i.e., their effect on those who completed them. Programs that do try to evaluate their training efforts often show positive results but tend to focus primarily on the reactive level. Because of this, most programs fail to show that training in consultation improves the quality or impact of consultation in services. An exception to this was an evaluation carried out at the University of Missouri School of Social Work of a continuing education project in mental health consultation and community organization from 1970 to 1973. Using a sophisticated "pre-post" methodology and some rather unique measuring instruments, the evaluation clearly showed that the training project significantly increased the participants' range

and degree of knowledge concerning mental health consultation, and the amount of time spent in work with the community (solid evidence of program impact). A change in attitudes towards consultation and some amount of skill development were also shown, but not as markedly. This evaluation is unique in social work, if not in the broader mental health field in general, in being able to offer data-based conclusions, demonstrating that training can be effective in increasing the impact of mental health consultation services (Rieman 1973).

Research

In reviewing the research on consultation, the same problem is encountered as when other aspects of consultation in social work are reviewed. Here, too, there is little that seems to set consultation by social workers apart from consultation done by other professionals. So far there has been no research dealing with the constellation of goals and objectives in social work consultation. This might well be a task for the future.

Some of the research on social workers as consultants and consultees has been reviewed by Kadushin (1977, pp. 188-197), and empirical studies on consultation across disciplines have been reviewed by various authors, for example, Mannino and Shore (1971, 1979); Medway (1982); and Meyers, Parsons, and Martin (1979). Because research is also covered by Kenney (chapter 15) in this volume, this material will not be repeated here. However, it is important to point out that in his review of the social work consultation literature, Kadushin (1977) found only seven studies over a period of 17 years where the research focused on social workers as consultants. Not all of these studies were conducted by social workers. When we add to these the studies already discussed in this paper which deal in some way with consultation by social workers--i.e., Perlmutter and Vayda (1979); Rieman (1973); Timberlake et al. (1982); Meares (1976); NASW News (1982); Kadushin and Buckman (1978); Austin and Kosberg (1978); and Mercer and Garner (1981)--it is apparent that research in consultation is not a high priority area for social work professionals.

One of the most recent studies of consultation practice in social work is the survey referred to previously (Kadushin and Buckman 1978). Although limited to social workers who designated consultation as their primary job function, it does provide some interesting information about consultation practice which is summarized here.

The largest single group of consultants (25.6 percent) was found to be affiliated with psychiatric-mental health facilities.

Other fairly large groups were affiliated with child and family services (18 percent) and with school social work units (17.6 percent). For the most part, consultees were agency supervisors, administrators, and direct service workers, and came mainly from health and mental health agencies, child care agencies, schools, and family service agencies. In most cases, consultees were seen on an individual basis (58.7 percent); however, 41.3 percent were seen in groups. Types of consultation most often encountered, in order of frequency, were client-centered consultation, program-centered administrative consultation, consultee-centered administrative consultation, and consultee-centered consultation.

It is difficult to interpret this finding concerning frequency of various types of consultation because the data seem to be based on the number of requests received for these different types of consultation, without taking into account the factors involved in the consultants' assessment of the situation--i.e., how they analyze the problem, what skills they bring, how they think about the problem conceptually, etc., all of which would enter into the final decision regarding the level of intervention for the consultant.

Some attempt to get at this was made in another section of the survey where the respondents were queried about their orientation to consultation. They were asked to point to their orientation on a 10-point continuum representing a pure process orientation at one end and a technical-assistance, problem-solving orientation at the other. The mean response of the consultants was 5.0, about midway between the extremes. School social work consultants leaned slightly toward the process side, while child welfare-family service and psychiatric-mental health consultants were decidedly more problem oriented. These findings regarding the orientations of the consultants tend to support the findings concerning the types of consultation. Both client-centered consultation and program-centered administrative consultation leaned more toward a problem-solving orientation than did the other types which were less frequently reported as encountered by the consultants.

Two other findings of importance were reported. One had to do with how expertise was attained. The findings indicated that many of the consultants gained their knowledge and expertise, not through their professional training in social work, but through working in highly specialized areas. Some examples were specialists in research methodology, in teenage unmarried motherhood, and in residential treatment centers. The final finding related to the fact that fairly high numbers of consultants indicated that no provision had been made for recording the consultation sessions, for providing for supervision of the consultation, or for any review

of the activities. The significance of this finding is clear from the viewpoint of quality control and evaluation.

One further source of research in the area of consultation by social workers is that of student research done in the form of dissertations for the doctoral degree. A recent study of such research through 1979 found 237 dissertations dealing with some aspect of consultation in mental health and related fields (Manino and Shore 1983). Of these, 10 (or 4.2 percent) were dissertations from the field of social work. Thus, we see that the number of student research theses in the area of social work consultation is quite low, not remarkably different from the field as a whole.

These 10 studies were analyzed along a number of dimensions, a brief summary of which follows. First, 7 of the 10 studies were done in the 1970s, which was the period when most of the dissertations in the larger study were done. Only one was done in the 1960s, and two were done in the 1950s, which suggest an early interest in consultation by the field of social work. As for location, something of a pattern emerges even with the small numbers involved. Both of the earliest dissertations were done at the University of Chicago. These were followed by one in 1966 and another in 1970, both from the University of Southern California. Two others were subsequently done at the University of Pittsburgh in 1972 and 1976. The remaining four were done at the Universities of Wisconsin, Michigan, Brandeis, and Utah. All of these, with the exceptions of Brandeis, Utah, and Chicago were among the 15 universities reporting at least five dissertations in the area of consultation. Another variable looked at was sex of the investigator. Of the 10 social work dissertations, 7 were written by males, which is not greatly different from the overall picture in the larger study in which 65 percent were written by males and 35 percent by females.

The subject areas of the dissertations were of interest. One focused on training issues, one on differentiating consultation from supervision, and a third on practice styles and characteristics. Five were concerned with various aspects of community mental health consultation, one with psychiatric consultation to a family agency, and one with licensing practices in child care institutions.

As to the settings for the research, 8 of the 10 studies specified the particular settings in which the study took place. Four were in community mental health centers, and one each in a family agency, a school system, a public welfare setting, and a child care setting. The remaining two were more general survey studies where no particular setting was involved.

As for the method used in these studies, three tested hypotheses. The rest were primarily descriptive in nature, did not use controls, and dealt chiefly with process aspects of consultation. None of the studies focused on outcome issues.

In short, the research contribution of social work to consultation practice has been slight. What is true for practice is also true of research--namely, that much of the research done by social workers is indistinguishable from other disciplines when the focus is on mental health consultation. Both mental health and social work are broad fields containing many similar principles. The fact that social work doctoral dissertations are done in the mental health area would seem to reflect this similarity.

Issues and Prospects

In this concluding section some of the issues already referred to will be put in the context of other related issues which may not as yet have been mentioned. Some of the strains in the profession which may be predictive of change will also be highlighted.

The issues in consultation seem to fall in two major areas. One area pertains to consultation as a specialty within the profession. The other is more overriding and general in nature and relates to developments in the profession as well as the larger society. As for consultation as a special area within the profession, a major problem seems to be that although, as has been noted, consultation can now be identified as a relatively distinct process in social work, it is still a process in search of a theory. This was essentially the assessment, also, of Meyers, Parsons, and Martin (1979, p. 38) in their study of consultation in schools. There are, of course, differentiating features of consultation that have been identified. For example, it is unlike supervision in that it is time-limited and it involves no administrative authority (Kadushin 1977, p. 40). Nevertheless, these differentiating features, even if they were beyond dispute, would not in themselves make a theory.

In the past, the main approach used by many consultants combined common sense with principles derived from clinical practice, largely psychodynamic in orientation. Recently, additional conceptual approaches have been brought to bear on consultation practice which place a greater emphasis on the person/environment interface, e.g., learning theories, systems theory, theories of organizational development, but it is not clear that any of these models are central to consultation practice in social work at the present time.

There are also, of course, difficulties relating to consultation, even as a distinct process. For example, there is the supposed lack of administrative authority of the consultant. Gaupp pointed out, as early as 1966, that authority, influence, and control are important elements in the consultation process and are variables that are much more complex than is generally realized (Gaupp 1966). The observation appears to be just as germane today. Thus, the lack of administrative authority may be spurious because it may be replaced by a more subtle form of authority, stemming from the consultant's association with the administrator, that is just as potent. Furthermore, perhaps it needs to be recognized that for consultants to help bring about programmatic changes they may need to have the kind of authority which can come from close association with the power structure.

Not unrelated to the above example is the ideological issue of goals and the kind of change that is envisioned by the consultant. To what extent is the consultant a change agent in the sense of changing policy, revamping programs, and helping to develop new resources as opposed to that of a support-facilitating agent who works with the consultee toward changing attitudes, helping to develop skills, and increasing knowledge in a specific area? Although much of the literature deals with the latter, two very interesting examples of working with communities toward developing new resources is Rieman's (1969) case study on community organization consultation and the well-known work of Collins and Pancoast (1976) concerning natural neighbors in informal helping networks. Work of this kind demonstrates the rather unique contribution of consultation to helping communities develop and organize their resources so as to become more responsive to the needs of their members.

Larger developments in the social work profession and in the political, economic, and social context of consultation are, however, also important. Will, for instance, the demand for social work consultants increase or decrease? Currently there seem to be pulls in both directions. On the negative side, there is the reality that we are in an age of retrenchment in the human services. Consultants, many of whom come from outside an agency, are very vulnerable in this respect and can quite easily be cut from a budget. More positive, only in the sense that more consultants could eventually be needed, are current trends in graduate social work education which may produce a need for more consultants. In graduate schools of social work the debate about the importance of specialization versus generic preparation has been rekindled once again. Stimulating this debate is the Council on Social Work Education which encourages "program diversity and minimum standards," as well as specialization in "fields of service" (CSWE 1982, pp. 2, 8). Both the fields-of-service

approach and the renewed emphasis on generalist skills are, in the writers' estimate, likely to increase the need for consultants. A field-of-service emphasis would be likely to produce specialists who need the consultant's help if, in an uncertain job market, they accept positions in areas in which they are less well trained, and the generalist would be no less likely to need this help because the training received might not have been sufficiently specific.

Other major issues concern trends that appear to be national in scope. One is the movement to deprofessionalize the public sector of social work. The so-called "declassification" of social work positions in many States, i.e., measures to allow non-social workers to fill positions formerly held by social workers, is a case in point. Even more threatening to the profession are proposals continually being made, tested, and contested to drop social service requirements altogether in a variety of settings. Hospitals are one example of this trend (NASW News 1982, p. 2), as are the public school systems which only recently received an infusion of social work practitioners under Public Law 94-142, but are now eliminating some of these same positions. What effect deprofessionalization will have on consultation is not yet clear. On the one hand it could discourage use of social work consultants because of the low priority of social services; on the other, a reservoir of need might thereby be created, ultimately leading to an even greater reliance on consultants able to assist those not adequately trained.

This predicament of providing consultation in settings where there is only a semblance of social services, and little likelihood that there would be a consistent followthrough in terms of recommended services, presents a problem for the consultant. The problem is an ethical one because the consultants would be, by their very presence, providing a rationale for maintaining an understaffed, low-quality service. This kind of situation was discussed earlier in relation to long-term care facilities.

An issue related to deprofessionalization in the public social services is, ironically, the increasing pace in the privatization of social work. Privatization in social work is illustrated by the increasing number of social workers in private practice and the increasing number of States regulating social work practice in the private sector (see NASW News May 1983, p. 1) while seemingly neglecting the public sector. In a national survey of NASW members in 1982, it was estimated that 12 percent of the 57,000 social workers who responded were employed in the private "for-profit" sector, most presumably in full- or part-time private practice. This represents an increase of 8.7 percent since 1972, when only 3.3 percent were so classified, a trend that needs to be taken seriously (NASW News Nov. 1983, p. 6). More pertinent to the

subject at hand is the finding that 3.3 percent of the social workers in private practice cited consultation as their primary activity (compared to 1.9 percent of all respondents to the survey). Thus the highest proportion of consultants came from a private for-profit setting (NASW News Nov. 1983, p. 6). In future years this considerable growth in private-sector, self-employed consultants could well continue, displacing the agency-based model of consultation. However, privatization would not necessarily have to be an untoward development if the public and private sectors can work together, holding the profit motive in check, and generally adhering to the same standards of sound and ethical practice. Nevertheless, it is a trend which should be closely monitored.

Finally, the need for additional research in all areas of consultation should be pointed out. Research on cost-effectiveness and consultant performance are just two facets of this need. Other research priorities would have to be (1) the strengthening of the theoretical foundations of consultation and (2) research on the profession's response to some of the ethical questions which have been posed throughout this chapter. The analysis of ethical dilemmas in social work has so far been very much neglected (see Reamer 1983, p. 35), whereas this chapter has demonstrated that in consultation such dilemmas can be numerous.

Summary

Social work consultants are filling increasingly important roles as the profession continues to evolve. This chapter, given its scope, could only outline the major features of these roles. While a number of issues were identified, there are many questions grounded in ideological and theoretical considerations, the structure of services, and preparation for the tasks social work consultants are called upon to perform that still must be addressed. Above all, consultation must be guided by the goals and values of the profession, a point stressed throughout this chapter. To fully realize its potential, consultation may well have to move further in the direction of greater attention to programs and services; yet without giving up its concern for the individual persons, families, or client groups who are, ultimately, at the receiving end of services. A major feature of the consultant's role in the future will have to be flexibility, i.e., flexibility to work with a range of consultees, from the individual to the community, at a variety of levels, with shifting goals and objectives as needed, and with the ability to move in and out of the consultant role whenever it is appropriate. Moreover, irrespective of the level of the intervention, consultants must design their

approach to work within the context of the environment so that change is not attempted in isolation.

The path ahead may be difficult, especially with the weakening of the national commitment to human services. The challenge to the profession is, however, not to lose its own commitment.

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CHAPTER 8

CONTRIBUTIONS OF PSYCHOLOGY TO MENTAL HEALTH CONSULTATION

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Involving others in the process of change is the shared task of many professional groups. Since this is so, consultation practice, theory, and research are also shared among the several professions represented in this volume. Psychology, two-headed profession that it is, has been involved heavily with consultation as a practice area and as a research area. Psychologists, certain psychological constructs, and accepted psychology research methodologies have been identified with consultation.

This chapter will focus on unique contributions from psychology to consultation. The following topics will be considered.

1. Evidence of the increased psychological practice of and research in consultation,
2. Obstacles within psychology to the development of consultation as a standard practice and research area,
3. Contributions from psychological theory and research to consultation,
4. Training in consultation among psychologists, and
5. Future of consultation within psychology.

Current Status of Consultation in Psychology

There have been published reports concerning consultation practice among psychologists since the early 1950s. The work of the psychologists at the Mental Health Study Center at the National Institute of Mental Health (NIMH) substantially predated consultation's national visibility through the Comprehensive Mental Health Act of 1963. It was this act that mandated consultation activity in the newly legislated community mental health centers. The publications from the Mental Health Study Center by psychologists Mannino and Shore (1971, 1972, 1975, 1979); Grady, Gibson, and Trickett (1981); and others (e.g., Clarke 1980) have served as the data bases for research and teaching efforts in psychology as evidenced by their frequent citation in the consultation literature.

In recent years there has been a tremendous increase in consultation textbooks written by psychologists (Alpert 1982; Alpert and Meyers 1983; Brown et al. 1979; Conoley 1981a; Conoley and Conoley 1982a; Curtis and Zins 1981; Dinkmeyer and Carlson 1975; Gallessich 1982; Meyers et al. 1979; O'Neill and Trickett 1982). The texts are tending to come from school, counseling, and community psychologists who, though clearly influenced by Caplan's (1970) prototypal work, are explicating consultation approaches with new emphases, theoretical understandings, and techniques.

In addition to the drastic growth in the availability of texts in consultation, journal reports of research findings have evidenced a steady growth since 1950. An analysis of the publications concerning mental health consultation in the NIMH annotated guides (e.g., Grady et al. 1981) indicates a substantial growth in journal literature from 1947 to the present. An average of 32 studies per year was done between 1947 and 1969; 98 studies per year were done between 1969 and 1973; while 221 studies per year were reported between 1973 and 1978.

Although mental health consultation has become a fairly well accepted and frequently written about topic in the psychology community, the writers of this expanding literature clearly perceive consultation to be on the periphery of mainstream psychological interventions. Some of the factors responsible for that phenomenon are discussed in the subsequent section.

Obstacles to the Development of Consultation in Psychology

Despite a large and growing psychological literature devoted to consultation, several factors tend to inhibit the development of consultation in psychology. These include historical and still-prevalent theories about change and pathology, role conflicts presented to the psychologist by consultation, training deficits, clinical press, and research and evaluation difficulties. Along with these inhibiting forces are parallel driving forces that represent recent developments in theory, research, and practice. The next sections will deal with each of these issues.

Theories of Change and Pathology

Psychological notions about change and pathology have been predominated by individualistic understandings. Until the late 1950s most practitioners and personality theorists saw the amelioration of psychopathology as taking place only through major

restructuring of individual personality (e.g., Freud 1964; Horney 1962; Murray 1969; Roazen 1974). The site of the pathology was clearly within the individual--a product of intrapsychic conflict and unresolved, immature, and uninterpreted psychological dynamisms.

It was not until the early 1960s that the 50 years of research in behavioral and social learning approaches became established as a practice approach among psychologists (e.g., Bandura 1973, 1977; Rotter et al. 1972; Skinner 1971, 1974; Stolz et al. 1975). The rise in behavioral understandings broadened intervention possibilities (Kazdin 1975; O'Leary and O'Leary 1976; O'Leary and Wilson 1975). Environmental manipulation was encouraged and direct work on "surface" behaviors was seen as an appropriate focus of therapy even by some theorists from the psychoanalytic school (Redl 1959).

Only still later was the work of Kurt Lewin (1935, 1948, 1951) widely disseminated among psychologists. The practical applications of his work and those following him are still not well known by many practitioners (Apter 1982; Barker 1968; Barker et al. 1978; DeRivera 1976; Hobbs 1966, 1975, 1982; Lewis 1982; Price and Politser 1980). However, Lewin's contributions in force field analysis and action research methodologies are critical concepts for consultants.

This gradual, and as yet incomplete, acknowledgment of the importance of social and environmental variables in the change process and in the etiology of psychopathology has slowed the acceptance of consultation into the armamentarium of psychologists. If pathology is within the individual, then working with caregivers is tangential. If change occurs only after personal insight into complex intrapsychic phenomena, then direct work with the client by a highly trained professional is indicated.

The experimental works of psychologists Watson and Watson (1921), Skinner (1953), Bandura (1969), and many others have been an impetus to broaden the individualistic view and include environmental modification, cognitive strategies, and systems change (e.g., Aronson and Bridgeman 1979; Chesler and Lohman 1971) as viable interventions. This person/behavior/environment perspective on the development of adaptive and maladaptive behaviors opens the door to consultation service delivery. Interventions aimed at multiple targets in the life space of the identified client become theoretically sanctioned and feasible. There has been, for some, a redefinition of where the problem lies.

Work by organization development specialists, especially those influenced by Lewin's work (e.g., Argyris 1970; Bennis 1969;

Lippitt and Lippitt 1978) is illustrative of the sophisticated analyses of environments that became an essential element in the consultants' repertoire. These analyses detailed physical environments, interpersonal dynamics, programs, administrative styles, worker attitudes, problem-solving and decisionmaking styles, and intergroup functioning. Notions of pathology were, in the main, discarded as consultants worked to create environments that were self-renewing and humane.

The concepts in general systems theory, originated in theoretical biology (vonBertalanffy 1952, 1967, 1968, 1974; Weinberg 1975), have been embraced by psychologist consultants in various settings—for example, schools (Gallessich 1982), business organizations (Capelle 1979; Cummings 1980), communities (Conoley and Conoley 1981; O'Neill 1981), counseling centers (Slaikeu and Duffy 1979), day-care facilities (Solyom 1981), libraries (Haas and Weatherly 1981), and many, many other service sites. The consultees chosen using a system's perspective are varied. They include caregivers such as pastors (Rumberger 1982), hairdressers (Wiesenfeld and Weis 1979), and bartenders (Cowen 1982; Cowen et al. 1981).

The problems people experience in learning, raising children, or running an organization arise from the complex of forces that act in every situation. The systems perspective emphasizes a movement away from simple linear explanations of events and promotes more attention to how all members of a troubled dyad, family, or organization are somehow acting to maintain dysfunctional behaviors. Current solutions being used by consultees are seen as part of the problem. There is a notable lack of emphasis on psychopathology in systems-based conceptualizations and interventions (Watzlawick et al. 1974). The focus is on problem solving rather than on an alleviation of pathology. Should systems theory become a prevalent orientation among psychologists, consultation might well move to the forefront of available change technologies. Psychologists in the family therapy field are most likely, it seems, to adopt this theoretical orientation (e.g., Haley 1973, 1976). Their close analyses of family dynamics have provided convincing evidence that the clients (or consultees?) cannot be understood without information about contextual variables (e.g., Hoffman 1981; Minuchin 1974).

Role Conflicts

Although great diversity exists among psychologists, they are most often influenced by an assumption that they will be the providers of services to vulnerable clients. Because their training socializes them in the complexities of psychopathology, they

naturally assume that high-level training and credentialing are necessary for the good of the clients (Sarason 1982; Tyler et al. 1983).

Such an orientation makes the practice of consultation an afterthought, or something to do when direct service is not possible. This tendency to value direct "healing" activities more than indirect preventive activities inhibits consultation from becoming a highly valued professional technique (Snow and Newton 1976). The economics of mental health care also poses an obstacle; third-party reimbursement for psychological services financially reward practitioners only for work that can be categorized with a diagnosis from the third edition of the Diagnostic and Statistical Manual of Mental Disorders, "DSM-III" (American Psychiatric Association 1980).

In addition, the practice of consultation often takes the psychologist out of the office and into the world of the client. Instead of insular independent practice, consultants must cope with the realities of organizational politics, limited resources, and highly variable understandings of what their contributions to an agency might be (O'Neill and Trickett 1982). Such a position can give rise to defensive reactions on the part of the consultant (e.g., Rae-Grant 1972) or push the consultant into the "world of action" (Goldenberg 1973).

Consultants' abilities to strike a helpful balance between objectivity and citizen responsibilities are difficult yet crucial challenges (Conoley and Conoley, in press). Widely differing views are expressed in the consultation literature as to how to manage this very important role question (Amos 1981; Chesler et al. 1976; Conoley 1981b; Gallessich 1982). Some writers propose that the role of consultant and advocate are mutually exclusive. The consultant, by definition, is to facilitate the work of an organization not to support a personal or constituency agenda. Training and ideology tend to cast the psychologist in the roles of mediator between conflictual groups or of observer and interpreter of social phenomena. Rarely has the role been conceptualized to include advocate or activist (Cormick and Lave 1976). In contrast, others point out the difficulty of separating advocacy from action. Any work that is done for an individual or group is an act of advocacy. Some acts are more publicly noticed as such, but the inherent conflictual nature between groups (e.g., students/administrators; workers/management; haves/have-nots) makes value-free action an impossibility (Gouldner 1969). The American Psychological Association (APA) code of ethics is instructive concerning this question, as is Gallessich's (1982) ethical code for consultants. Ultimately the separation between scientist/practitioner and citizen may be seen as needless reductionism (Heller et al 1984).

Self-conscious practice that invites peer review may be the only goal that can be reasonably sought.

Training Deficits

Training will be dealt with at some length later in this chapter and in another part of this volume. Most graduate training programs in clinical, counseling, and school psychology do not offer formal courses in consultation (Meyers et al. 1981). Very few trainers in these fields have, themselves, taken a course in consultation and may not see the relevance of such formal preparation. Although many skills necessary for consultation may be taught in graduate school, critical reviews of systems theory and organizational dynamics may be especially lacking in clinical and counseling programs. Community and school psychologists are more likely to have received formal consultation training. Their numbers are, however, relatively small compared to their clinical and counseling colleagues.

Clinical Press

As predicted over 15 years ago (Albee 1968), there are not enough mental health workers to meet the needs of an ever-growing consumer group. Moreover, there are not the governmental resources to support services to indigent groups if trained personnel did exist. The problems are bigger and more complex than ever before and the resources smaller and more tenuously available. This situation, present in all areas of human services, creates what has been termed the "clinical press"--that is, do something about the people sitting outside the door, those with the most profound disabilities, and those with the least chance of satisfactory recovery of coping skills. In the jargon of the community psychologist, "the squeaky wheels" and the "empty buckets" demand and receive the lion's share of attention with little programming time available for preventive, proactive services.

Such a climate is, obviously, not conducive to consultation practice. By definition, consultation is aimed at increasing caregiver skills, not immediately alleviating client distress. The pay-off in terms of skills enhancement and generalization is potentially great, but necessarily long-range. Direct service modalities are far more popular in the current situation of great need and few resources. It is ironic that there is no time to use the technology that has been shown to reduce the clinical press (Wixon 1980) because of the clinical press. Mental health workers would, it seems, fail an ancient test of sanity (Sarason and Doris 1979). We try to empty the pool of water (needy clients) by scooping it out

(direct service) instead of stopping it at its source (preventive, proactive strategies).

Research Difficulties

Published research and evaluation in consultation have steadily increased and improved (Mannino and Shore 1979; Medway 1979, 1982). Difficulties are, however, inherent in doing consultation research. Field studies tend to report data which are better conceptualized as evaluative information than as research findings (e.g., Meyers 1975; Ritter 1978), and control issues are pervasive. Consultant skill, severity of presenting problems, time spent on consultation, receptivity and skills of consultees, and organizational openness to mental health services are all potential variables exerting influence on consultation outcome studies. Some of these variables can be controlled in analog research efforts (e.g., Conoley and Conoley 1982b; Tombari and Bergan 1978), but others defy easy manipulation in natural setting studies. This being the case, the balance between internal and external validity concerns remains an area of continuing difficulty for consultation researchers.

In addition, the delineation of the appropriate change target is difficult. Mannino and Shore (1975, 1979) have identified clients, consultees, and systems as deserving attention in consultation studies. Input, process, and outcome variables must also be considered. If the effect of consultation is preventive, the criterion measure becomes illusive. If the purpose of consultation is to begin a process of change that "ripples" through an organization, data collection must be comprehensive enough to measure intended and unintended consequences.

Despite these difficulties, several psychologists have managed to implement programmatic research in mental health consultation (e.g., Alpert 1979; Alpert et al. 1983; Alpert et al. 1979; Alpert and Rosenfield 1981; Alpert et al. 1980; Bossard and Gutkin 1983; Gutkin 1980, 1981; Gutkin and Bossard, in press; Gutkin and Curtis 1981; Gutkin et al. 1980; Mannino 1964, 1972, 1981; Meyers 1973, 1975, 1978, 1981; Meyers et al. 1975; Meyers, Friedman, Gaughan, and Pitt 1978; Meyers, Pitt, Gaughan, and Friedman 1978). Extremely productive research in behavioral consultation has been accomplished by Bergan and his associates (Bergan and Newman 1980; Bergan and Tombari 1975, 1976; Tombari and Bergan 1978). The increasing use of control groups, multivariate statistical techniques, carefully defined consultation techniques and subject populations, and analog studies to investigate process and outcome variables with rigorous control are all recent improvements in consultation research.

This section has delineated driving and inhibiting forces acting upon consultation in the broad field of psychology. The next portion of this chapter will review the major theoretical and research developments in psychology that have played an important role in the growth of mental health consultation.

Psychology and Consultation

Social psychology, program evaluation, social learning theory, behavioral/intellectual/personality assessments, and theories of clinical and counseling psychology are, perhaps, prime contributions from psychology to mental health consultation. Each of these areas has provided models for research in consultation in addition to building the basic data bases of intervention techniques.

Social Psychology

It is impossible to overestimate the contributions from social psychology to the practice of consultation. Studies relating to social influence (Asch 1956; French and Raven 1959; Milgram 1974; Raven and Haley 1980), leadership (Cartwright and Zander 1968; Gibb 1969; Hollander and Julian 1970; Michener and Lawler 1975), small group process (Bales and Cohen 1979; Deutsch and Krauss 1962; Wahrman and Pugh 1974), cooperation and competition (Aronson et al. 1978; Thibaut and Kelley 1959; Sherif et al. 1961; VanEgeren 1979), and attribution (Frieze and Snyder 1980; Heider 1958; Kelley 1972; Rosenthal and Jacobson 1968; Schachter and Singer 1962; Wong and Weiner 1981) have been a basis for position papers and research in consultation literature.

Studies concerning expert and referent power in consultation are examples of work growing directly out of social psychological constructs (Martin 1978; Martin and Curtis 1981). Hughes and Falk's (1981) and Hughes's (1983) papers investigating the relationship of consultation to attribution, reactance theory, and cognitive dissonance are related developments. Gallessich (1973, 1974, 1982) incorporated many concepts from social psychology, for example, subgroup norms, leadership dimensions, and organizational cultures in her suggested training sequence for consultation.

The most obvious consultant consumers of social psychology literature have been those psychologists interested in organizational change either through action research as a primary strategy or through the more complex activities associated with organizational development (Argyris 1970; Argyris and Schon 1978; Beckhard 1969; Bennis et al. 1976; Blake and Mouton 1979; Bowers and

Franklin 1977; Friedlander and Brown 1974; Lippitt 1969; Matuszek 1981; Price and Politser 1980; Steele 1969; Walton 1969). In addition to applying social psychology, these psychologists have been the generators of considerable information and theory.

Program Evaluation

The combination of Lewin's (1947) action research conceptualizations and the massive infusion during the 1960s of federally funded programs demanding evaluation components gave birth to the field of program evaluation. The technology developed by psychologists in this field (e.g., Cronbach 1982) has both directly and indirectly affected the practice of consultation. Practitioners of program consultation scrutinize context, input, process, and product variables (Stufflebeam et al. 1971) as a direct service to organizational consultees. In addition, consultants familiar with needs assessment techniques and evaluations to develop programs or assess the match between desired and actual goal attainments (Provus 1971) have utilized these skills in diverse service sites.

Less directly, the axioms of program evaluation--i.e., (1) set measurable goals, (2) match the goals to the needs of a constituency, (3) continuously assess performance, and (4) feed information back for program modifications or decisionmaker action--are all cornerstones of good consultative efforts from any theoretical orientation. The program evaluators' goal to improve the functioning of a host organization is essentially the same as the consultants' goal. Differences exist between the two roles, but both borrow heavily from one another to achieve high levels of success (Matuszek 1981).

Social Learning Theory

A key role played by the consultant is that of model to the consultee organization. Modeling had been found to be a powerful teaching/learning tool in psychological research (Bandura and Walters 1963). Consultants not only utilize the principle directly in their work but often find that cognitive learning strategies play important parts in the plans they develop with consultees (Goldstein 1981; Goldstein et al. 1983).

Results of experiments in vicarious reinforcement (Bandura 1969), model characteristics (Bandura 1977), effects of reinforcement and punishment (O'Leary and Wilson 1975), cognitive learning techniques such as imagery and self-talk (Meichenbaum 1979) are pervasively apparent in the work of mental health consultants. It is also apparent that constructs such as theme interference

have parallels in the cognitive therapy approaches. Ellis and Grieger's (1977) description of irrational thoughts is a very close approximation of Caplan's unconscious dynamic. Just like Caplan, Ellis (1973) suggests that the actions, feelings, and attitudes of clients are often products not of clients' direct experience, but rather products of their unexamined beliefs about such situations. Ellis's therapeutic techniques differ dramatically from Caplan's suggestions but not so far from Meyers et al.'s (1979) or Gross's (1978) ideas of appropriate consultant interventions. These authors suggest that direct confrontation of consultee themes is often appropriate and does not result in disabling anxiety for the consultee.

Assessment

The success of consultation is primarily dependent upon a successful description of the problem. Caplan (1970) saw the discovery of the underlying issues preventing consultee competency as the most critical consultation task. From a very different theoretical perspective, Bergan and Tombari (1976) reached the same conclusion. Writing from a behavioral orientation, they were able to show that when consultants and consultees shared a behavioral understanding of presenting problems, the success rate in solving the problems through consultation was 95 percent.

Thus, the whole area of diagnostic assessment is of particular interest and importance in mental health consultation. Practitioners may eschew the use of traditional diagnostic tools in favor of more ecologically or behaviorally based assessment procedures (Achenbach and Edelbrock 1983; Apter 1982; Apter and Conoley 1984; Carlson et al. 1980; Conoley 1980; Keller 1981) or may use traditional concepts in innovative ways (Meyers 1981).

Psychology has been the source of both assessment devices and assessment methodologies. Consultants are frequently used as experts to integrate assessment data on intellectual, emotional, and adaptive functioning. In addition, mental health consultants are often directly involved in specialized assessment procedures. For example, school districts regularly employ consultants to supervise the diagnosis of emotional disturbance in children.

Consultants inevitably utilize assessment procedures such as behavioral analysis, group process analysis, ecological assessment, action research, or program evaluation and frequently teach their consultees the appropriate use of such procedures. Since a primary goal of consultation is to promote the problem-solving capacity of an individual or organization, teaching self-assessment strategies is an important intervention.

Psychology consultants show a strong propensity to assess their own functioning and develop devices to accomplish their measurement tasks (Bergan and Tombari 1976; Cherniss 1978; Curtis and Anderson 1975). This is, no doubt, a partial legacy from psychology's historical concern with measurement, individual differences, and empirical data.

Clinical and Counseling Theories

The massive literature concerning research validation of therapy and counseling techniques and notions about the etiology of psychopathology has had a profound effect on consultation. Written accounts of consultation techniques emphasize verbal processes that had their origins in counseling techniques. These include rapport building, careful listening, skillful feedback skills, reframing, establishing "ownership" of the problem, increasing motivation through cognitive restructuring, and a focus on the present.

The seminal works of Carl Rogers (1942, 1946, 1956, 1957, 1961, 1977) are perhaps the most influential among practitioners of consultation. In addition, these works have provided a framework for research into the processes necessary for successful consultation. The core ingredients identified by Rogers for therapists have also been found to be indispensable for consultants (Robbins and Spencer 1968).

Other therapeutic orientations have been incorporated into consultation. Transactional analysis (Berne 1961; Harris 1969) has been adapted to mental health consultation by several consultation researchers (Fine et al. 1982; Keeney 1978; Parsons and Meyers 1978). Aspects of behavior therapy (Bergan 1977; Keller 1981; Medway and Forman 1980) have influenced the work of consultants in terms of assessment, intervention, and most crucially, orientation toward the importance of environmental caregivers. Caplanian mental health consultation is, of course, replete with influences from classical psychodynamic theory. This is clear from many constructs such as theme interference, identification, and effects of history and from the expert, disengaged role espoused for the consultant. A combination of Rogerian techniques and rational emotive therapy are suggested by Meyers, Parsons, and Martin (1979) at certain stages of the consultation relationship. It is probably safe to say that elements of all the "mainstream" therapies have been employed by consulting practitioners, and many of these have received attention in the consultation research literature.

Another contribution from psychotherapy research is the prescriptive research model (e.g., Goldstein and Stein 1976). The approach is an outgrowth and elaboration of psychology's longtime interest in the effects of individual differences on treatment outcome. This research orientation recently has been adopted by consultation investigators (e.g., Barge 1984; Conoley and Conoley 1982b; Jason et al. 1979; Rodda 1983). Essentially, the goal is to match consultant, consultee, consultation approach, problem, organization, and client characteristics to facilitate optimal outcomes. As such, the model provides a helpful framework to plan research programs that have the potential of building upon each other.

Consultation Training

Despite the obvious relationship of training to practice, only very recently have consultation training curriculums been made available in the literature. Psychologists, it seems, have tended to believe that consultation is simply information-sharing requiring no specific training.

There is growing evidence that specific training in consultative theory and practice is advantageous (Berlin 1965; Conoley 1981c; Curtis and Watson 1980; Plog 1977; Stringer 1961). The old adage suggesting that if all other occupations fail, one can still turn to consultation as a last resort seems not to have received empirical support.

A growing number of trainers have published descriptions of training sequences (Alpert 1982; Babigian and Pederson 1972; Barclay 1967; Bergan 1977; Cohen 1976; Conoley 1981c; Conoley and Conoley 1982a; Gallessich 1974, 1982; Goodwin et al. 1971). They blend theory, experience, supervision, research, and evaluation methodologies. Often small group work is used extensively (Alpert et al. 1980).

Gallessich (1974) presents a particularly attractive framework because of its theoretical breadth and practical intensity. She covers mental health, behavioral, process, and advocacy understandings of consultation in her teaching. In addition, Gallessich emphasizes entry issues, personal growth and understanding of students, feedback skills, and practical experience. Social psychology and systems theory are the main theoretical roots of her approach.

What are lacking, unfortunately, are large-scale evaluations of the strategies she suggests. Conoley (1981c) reported data on a sample of 56 trainees indicating both trainee and placement site

satisfaction with the training process. She also compared supervisor ratings of students trained with the Gallessich method and those who received no consultation training. Students who received consultation training were consistently ranked higher than students with comparable training in other areas but without preparation in consultation.

Training in behavioral consultation has been expertly evaluated (Bergan 1977; Goodwin et al. 1971; Suinn 1974). The behaviorists' emphasis on competency based training is of substantial importance from any theoretical orientation (Bergan et al. 1980; Froehle 1978; Kratochwill and Bergan 1978).

Cohen's (1976) description of two consultation training sequences is important especially in terms of its use of the Harvey, Hunt, and Schroeder (1961) conceptual systems. It lacks enough elaboration to make it useful, however, in actually planning a total training experience in consultation.

McGreevey's (1978) coverage of issues that are important to address in training is an excellent source for consultation trainers. He targets some cognitive understandings (e.g., person-system interrelationships, authority, responsibility), analytic synthetic skills (e.g., needs assessment, problem formulation, reframing, negotiation), and interpersonal skills (e.g., communication, modeling, self-confidence) as important goals for training.

Lambert, Yandell, and Sandoval (1975) present a training sequence including the gradual growth of the student consultant from classroom observer to classroom resource, thus providing the student with increasing information and self-confidence. In addition, they emphasize the student's personal growth and awareness as important educational outcomes. Close supervision is, therefore, an integral part of their consultation training.

Student concerns have been identified among psychology trainees in consultation. Trainees identify anxieties associated with entry into consultation organizations, lack of knowledge in areas perceived as necessary by consultees, difficulties with conflict between themselves and consultees, lacks in sensitivities to complex territorial concerns between themselves and existing support staff, and ambivalencies about the usefulness of the consultant role in the face of serious clinical presses. In addition, the trainees also evidence difficulties with supervisory emphasis on personal growth, giving and receiving of personal and professional feedback, dealing with university and field supervisors, and taking responsibility for structuring their own supervisory times. In spite of this long list of problems, high levels of student satisfaction

with the training experiences also have been reported (Alpert et al. 1980; Conoley 1981c).

A national conference on training in consultation was held in Montreal in 1981. This allowed the first dialog between practitioners and trainers in school, community, industrial, clinical, and counseling psychology. The major papers given at the conference have been published (Alpert and Meyers 1983), and the long-sought-after sharing process among trainers and practitioners has begun. Next steps that might emanate from the conference experience may include development and dissemination of training methods (videotapes, study guides, useful training simulations to promote learning), cooperative research efforts among university and field personnel, evolution of consultative theory to keep abreast with psychology and related area breakthroughs, and a more thoughtful confrontation with the future of mental health consultation as conceptualized by practitioners, researchers, and trainers in diverse settings.

Future of Consultation in Psychology

Having reviewed the past scholarly contributions from psychology to mental health consultation, it is timely to look toward the future. The future of mental health consultation is closely tied to that of psychology and the other mental health disciplines represented in this volume. Mental health consultation will be affected by the fortunes of the fields of psychology, social work, and medicine. The following section will speculate on the future of practice, theory, and research in mental health consultation uniquely within psychology.

Psychologists have increasingly entered the field of health service provision. While practitioner psychologists were rare before World War II, they now number in the many thousands. The specialties of clinical, counseling, school, organizational, and community psychologists now make up the bulk of applied psychologists offering some type of health service to consumers. Different academic departments in universities control the training of each of these specialties. Only school and community psychologists routinely receive training in consultation. Some community psychologists receive no training in traditional psychotherapy, diagnostic, or interviewing skills.

A change in the way psychologists are trained and credentialled for practice may well be an aspect of psychology's future. There is already a suggestion that universities train generic clinical psychologists—that is, those who would qualify for membership in the National Register of Health Service Providers—in contrast

to training in the different specialty areas. If such a transition should occur, what would happen to mental health consultation training? The question does not pertain to the existence of one or two courses available to students in such a generic preparation program. The question is one of basic orientation toward the unique role of the psychologist. How will psychology's historical concern with the individual be balanced and augmented with the growing organizational, sociological, and anthropological awarenesses of the contemporary community and school psychologists?

Several speculations grow from this analysis. Perhaps psychologists will be trained like physicians--i.e., several years of generic training with specialization occurring only during the internship or residency. The American Psychological Association's (APA) activities in the designation of psychology programs and the accreditation of specialties could create such generic graduate training. The National Register of Health Service Providers and the American Board of Professional Psychology could expand their roles into the monitoring of internships and residency programs. Success of this model of training would depend on the APA influencing State boards of examiners to license only graduates of APA-approved programs.

The designers of the generic portion of the preparation would be faced with defining psychology as a service profession. The questions concerning the etiology (or existence) of psychopathology, a definition of mental health, the optimal role of the psychologist, and the psychologist vis-a-vis other mental health professionals would all require careful attention. If the future holds an ascendancy of either our historical emphasis on the individual or our newly discovered fascination with the community, the long-term viability of psychology will be compromised. The training programs of the future must shape practitioners who understand the complexity of the individual in the social context and the nuances of context that are amenable to psychological intervention. Interdependencies, recursive cycles of behavior, positive and negative feedback loops that maintain dysfunctional behaviors, and nonblaming acceptance toward diverse lifestyles must become cornerstone concepts in future training.

Each of the existing specialties will have to "give" a little. For example, clinical psychology will have to integrate notions like "life space," "ecological balance," and symptoms that are explainable and adaptive to a social context. Community psychologists will have to see individuals as having complex histories that do influence their current behaviors. Some people must have assistance in reinterpreting past events before adaptive functioning is possible. In addition, psychologists must center their thinking on the individual or be doomed to spend many years as naive

sociologists and anthropologists. Such centering does not imply an ignorance of the effects of social forces but a promotion of the importance of skills in psychotherapy, interviewing, assessment, or, at least, interpersonal exchange and social influence.

Not all problems can be solved by psychologists with the existing technologies. But psychologists trained with a theory of human behavior that highlights person/environment interaction and a repertoire of research skills that include experimental and action research strategies can influence or collaborate with other consumers and professionals to exert considerable influence in improving the condition of humankind. The future of mental health consultation will be strong in such a context. It will not be seen as a frill with questionable effectiveness. Rather, mental health consultation will be a basic technology for bringing people back into "balance" with their environments--students, parishioners, prisoners, organizations, or communities. Such balance is achieved through individual change in skills, attitudes, and beliefs about self and others; manipulation of the social, emotional, or physical environment of individuals through group therapy, organizational development, ecological consultation, and program evaluation; and the promotion of social causes that affect human well-being through expert application of scientist/citizen advocacy strategies.

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CHAPTER 9

THE MENTAL HEALTH DISCIPLINES AND THEIR APPROACHES TO CONSULTATION: A COMMENTARY

James G. Kelly, Ph.D.

This commentary will emphasize the impact of the socialization of professional roles upon the delivery of consultation. I am arguing (1) that the history of each of the mental health professions has had an impact upon how mental health consultation has been defined and presented by each of the four disciplines, and (2) that the disciplinary heritages and economic and social roles that each of the professions plays within the human services field both provide opportunities and impose constraints for defining consultation as an essential part of the repertoire of that profession. Thus I am arguing for a contextual understanding of how various consultation roles are defined and expressed.

First let me comment on my own perspective to give readers some background for my comments. I have been doing and teaching consultation since 1958. My tutors were Erich Lindemann, Don Klein, and Gerald Caplan. I view consultation as a preventive activity. My interest and rationale for doing consultation are to improve the resourcefulness and adaptation of organizational settings. I still believe in the utility of mental health consultation as originally articulated by Lindemann and Caplan.

I believe that the potential of mental health consultation as a preventive service has not been realized. This is due not only to the difficulty of generating occupational role changes for consultees, but because societal expectations for the mental health disciplines have hindered the absorption of a community-oriented/prevention focus when carrying out consultation.

In a real and substantial sense the concept of prevention, with its aspiration to reduce the expression of disease, is an antagonistic activity for many professionals. In fact the political and social currency and validity of most professions relate to the treatment of known cases of persons in distress. It is also not easy for trained professionals to shift styles of work, from a characteristic hierarchical work setting where there is validity in the social role of being an expert to a more open-ended professional

role where the diagnosis of individuals is replaced by the task of assessing organizational norms and informal leadership in social settings where the mental health consultant is a guest or outsider. Doing consultation work demands new ways of thinking and carrying out professional tasks where there are often few hallmarks or traditions and fewer established guidelines for what is expected of the professional consultant. There are also fewer social supports within four mental health professions for new and novel professional roles to be developed and adopted.

The community mental health movement, since its inception in the 1960s, has generated opportunities for members of the core mental health disciplines—nursing, psychiatry, psychology, and social work—to adapt their own traditions and perspectives to the delivery of a new type of mental health service in which the mental health professional as a consultant provides an indirect service, i.e., offers advice and counsel about a client through another professional person, the consultee. The consultant often does not work directly with the client, but only with the consultee.

The prototypic example is the consultant working with a classroom teacher to help the teacher cope more effectively with topics of assessment, counseling, or therapeutic intervention with students. As the literature confirms, this work has been extended to include consultees such as clergy, police officers, directors of human service organizations, public health nurses, and other key members of the helping professions. Each of the core mental health disciplines then has attempted to work from its unique perspective to define a professional role in community mental health, i.e., to interpret the meaning of community mental health within the role repertoire of that discipline.

My comments will focus on how the unique historical roles of the four disciplines have affected consultation activity.

Nursing

One of the intriguing aspects of the nurse's role as a consultant is the degree to which social status, prestige, and professional accomplishments affect the identification of a consultant as a specialized expert. The nurse has difficulty in being perceived by other mental health disciplines as a consultant (expert) since the profession of nursing is still working out ground rules for achieving status as a profession. As pointed out in the papers on nursing by Lisa Robinson and Lucy Ann Howard, a nurse usually develops an opportunity to do consultation only after taking courses for the master's degree. At this level, the nurse is just beginning to attain a level of professional standing. What normally happens is

that a generically educated nurse receives consultation from a degree-holding nurse. The practice of consultation is retained within nursing via close working relationships between the nurse holding a master's degree as consultant and the generically trained nurse as a consultee. While such a pattern of nurse-to-nurse consultation is advantageous as a means of staff development for the less trained nurse, this pattern restricts the nurse consultant from having access to and affecting other disciplines.

While the formal recognition of consultation as a professional role is not well developed within the nursing profession, the consultation role can be expressed informally as nurses generate support and advice within the nursing profession as they carry out their professional work on a daily basis. I suspect that the practice of professional consultation as defined via the informal give-and-take within relatively close and mutually sustaining professional work relationships has limited nurses from expressing their competence as consultants with other disciplines.

A generic quality of consultation is pointed out in Lisa Robinson's paper--namely that, at least in the early history of the consultation relationship, the more difficult, challenging, perplexing, or severe cases are referred to a senior nurse consultant. This is understandable, given that within the psychiatric nursing profession there is social status attached to making valid professional decisions about the management of difficult and intractable patients. The nurse consultant may be asked by the nurse consultee to help clarify a diagnostic or treatment decision. The nurse consultant in this instance is defined as an expert to clarify immediate decisions about the case management. Given the aspiration of the nursing profession to elevate its professional status, the role of the consultant as expert witness is very appealing. Yet while the performance of such expert activities (which emulates the social norms within medicine) may gain the consultant increased social status, it may reduce any incentive for the nurse consultant to develop roles which are closer to community-based prevention.

A fascinating and troublesome issue for the performance of consultation roles by the nursing profession is pointed out by Lisa Robinson. This is the gender-specific aspect of the nurse's roles--namely, that the authoritative, assertive, commanding style associated with the consultants may be difficult to fit with female stereotypes. Women have not been perceived to be authoritative, and there is an equally strong tendency for women to work informally. To the extent that most members of the nursing profession are women, gender-specific role constraints may limit opportunities for women nurses to be perceived as

competent by other disciplines, particularly when the members of these other disciplines are often men.

This observation implies that generating a more broadly preventive or organizational role may be limited for the nursing profession unless societal and cultural norms change so that the professional woman nurse can be perceived as a competent and commanding resource. Being a consultant in many situations implies that the consultant has earned respect and achieved a high social status. Historical precedent suggests that it is more difficult for other professionals, particularly senior male professionals, to perceive a woman nurse as an accomplished resource. The aspiring community-oriented nurse has to overcome the stigma of sex discrimination in moving outside the nursing profession and into the larger community arena.

While the nursing profession may not be a dominant force in the delivery of community-based mental health services, certainly the nursing profession has been a frequent consultee for the other members of the mental health professions. For example, a critical resource in the delivery of community-based preventive mental health services is the public health nurse who has knowledge of community dynamics and a longstanding commitment to preventive health care, while also meeting challenging goals of immediate service delivery. In my opinion future research on consultation should make use of the dominant role nurses play as recipients of consultation. In this sense, the public health nurse is in a key position to evaluate consultation and to be a resource for analyzing what aspects of a consultant's behavior are in fact useful or productive in helping consultees meet the needs of clients. While the nursing profession continues to define its own professional role in the mental health professions, nurses can also be significant critics and evaluators of consultation.

Lucy Ann Howard presents several potential new directions for the role of the community mental health/public health nurse as a consultant. Particularly intriguing are opportunities for both the community mental health and liaison nurse to express a prevention philosophy--so closely identified with the tradition of community mental health/public health nursing. One clear opportunity is consulting with chronically ill patients and the community and social organizations which serve the chronically mentally ill. A major need is for a nursing consultant to assist the client and the service providers to create an integrated network of services so that the client does not get lost within a fragmented services system.

The limitation of community mental health services is not in the philosophy but the fact that the rehabilitation or integration

of the mentally ill within the community depends upon an effective coordination and shared commitment of treatment goals by a variety of home care, employment, medical, and nursing services. The nurse is in a particularly strategic position, via the consultant role, to activate the integration of services. Such consultation can also facilitate coordination and collaboration between the mental health service system and the various advocates of self-help groups for the mental patient. As Lucy Ann Howard points out, the changing revenue constraints affecting the delivery of mental health services offer an opportunity for alliances to be formed between the psychiatric client, self-help groups, and service providers in order to improve the quality of care provided by each and to lobby for badly needed resources. The nurse consultant may be the preferred catalyst because the nurse may have a very good command of the intricacies of the service program. The nurse is often the one professional who has earned the trust of patient, service provider, and self-help groups.

With the increasing national investment in rural mental health services, the nurse consultant can build upon a longstanding appreciation and community trust for the nursing role that has evolved in rural communities, i.e., the perception that a nurse is a major source of knowledge about accessible and comprehensive service delivery. The power of consultation as an indirect service can be realized as the nurse carries out consultation with the often-scattered essential services in rural areas. The potential evolution or the craft of consultation can be elaborated as the nurse consultant works with the chronically mentally ill and with the rural community. Lucy Ann Howard's chapter makes the prospect compelling and fulfilling, both for the nurse and those members of the mental health professions who are invested in prevention.

Psychiatry

The profession of psychiatry is the dominant profession within the mental health field. This dominance relates partially to the value American society has historically placed upon the M.D. degree, as well as to the significance of psychoanalytic treatment within the mental health professions as a preferred and widely used theoretical orientation. The early works of Erich Lindemann and Gerald Caplan, both public health psychiatrists, in articulating a psychodynamic crisis theory for the practice of mental health consultation were landmark contributions for all of the mental health professions. Yet, despite this impressive early definition of the field, the role of the psychiatrist as a community mental health practitioner has been limited. Few psychiatrists choose public health psychiatry as a career. As John Schwab

points out in his chapter, the decline of community mental health centers has further eroded the opportunities for the psychiatrist to become engaged as a practicing part of the community mental health enterprise.

However, there are some significant latent contributions that the psychiatrist can and does make to the field of consultation which at the present time have not become a focal point for empirical research. The integration of psychoanalytic and psychodynamic concepts with organizational concepts provides an excellent opportunity to create knowledge for such topics as resistance to consultation and to elaborate consultation practice within the arena of organizational change. Insights about intrapsychic processes provide a cornerstone for developing such an integrative theory. More interdisciplinary connections between the fields of clinical-community psychiatry and organizational psychology can help make this an enriched craft. While this potential is certainly feasible, there are many constraints on the evolution of the psychiatrist as practicing consultant.

As John Schwab points out, there are several major impediments. One is the increasing dominance of the biological perspective within psychiatry affirming an earlier, more scientific, basis for the psychiatrist as a physician. As this emphasis increases, there is less opportunity for the psychiatrist to have access to training opportunities and professional roles where a young psychiatrist can practice community-based consultant roles. Second, as the community mental health center program has declined, there are fewer professional career roles available for the psychiatrist to articulate the range and depth of community consultation. Third, with the increased technological advances in medical care, the need and attention of the psychiatrist has shifted to the compelling and essential psychiatric aspects of life-threatening illness, particularly as such illnesses affect not only the immediate family of the person with catastrophic illness but the roles of the medical staff who provide care for such patients. While the concepts of community mental health are salient to view the patient as part of a family or hospital system, the potential of mental health consultation inside the hospital has not been tapped.

Another factor is the tendency for the psychiatrist to serve upper- and middle-class patients, rather than lower-class clients, and thereby failing to achieve an understanding of the needs for service delivery in a broader context. The plentiful number of affluent clients available for psychiatric treatment is certainly a dominant force in preserving the traditions of the psychiatrist serving a higher social stratum of society. A complementary factor is the consultative role that the psychiatrist has developed in the care and treatment of medical and surgical patients. In

some significant ways the status of psychiatry within the field of medicine is dependent upon the psychiatrist understanding the psychological and mental health features of all forms of disease. With such opportunities—if not obligations within the medical profession—for consultation inside the hospital, the psychiatrist is further pulled away from developing consultative skills to lower-class patients in the community at large.

John Schwab outlines a further constraint in the delivery of a community approach within the field of psychiatry, namely the cost and payment of services. To the extent that the psychiatrist, as part of medicine, is embraced in the delivery of care by third-party payments, there is a dominant incentive and tradition for community psychiatry services to be guaranteed in advance. Since a significant portion of clients from community agencies serve clients of lower socioeconomic status, it is problematic that competitive fees can be arranged or guaranteed for the psychiatrist to serve these clients. With fewer pledged financial commitments from lower-class clients, or fewer agreed-upon solutions to provide consultation fees, the psychiatrist interested in carrying out community consultation is faced with few choices but to continue to provide services where there is an agreed-upon and well-worked-out system of payment.

When psychiatrists do engage in community-oriented consultation, there is a major aspect of the psychiatrists' role image that seems to limit redefining their role to provide a community-oriented service. This is the role of the psychiatrist as an expert. When the psychiatrist is perceived as an expert, the consultant relationship is defined so that the consultant transmits facts, points of view, personal judgments, and advice to the consultee. In this transaction, the consultee is unwittingly pulled to respond in a passive and perhaps dutiful manner. Even more importantly, the nature of the expert role creates a set of role expectations in which the consultees do not perceive themselves as an active force in creating an organizational climate for changing a particular condition, but may learn instead to defer to expert opinion. With extensive societal support for consultees to seek out expert opinion, the psychiatrist who wishes to facilitate community development must overcome major role expectations of the consultee's for a more protected relationship. It takes a tremendous amount of role clarity, commitment, and patience for the psychiatrist to shift gears, to put aside the encumbering role of the expert, and to adopt and model consultation skills that focus upon the consultation relationship as egalitarian and as a source for problem solving.

The chapter by John Schwab affirms the significance of the concept of socialization to explain the expression of professional roles. The powerful and unyielding social roles for the physician seem to limit the prospects of the physician being a community-oriented professional. The paradox, however, is that the knowledge that is developed within the practice of clinical psychiatry, particularly knowledge related to resistance to change and motivation to seek health, is essential to understand the consultation process. All professionals active in carrying out consultation can continue to benefit from continued elaborations of psychodynamic principles. The unique perspectives and insights of the clinical psychiatrist are fruitful even though the role of the psychiatrist may not often be realized as a consultant in community settings.

Psychology

The literature within the field of community psychology contains many references to the role of mental health consultant, particularly the role as originally identified within the community mental health field. There have been fewer references, however, to the consultation literature generated from the field of organizational psychology. The latent potential to integrate these two disciplines and points of view about consultation within psychology has not yet materialized. This situation reflects a characteristic of the field of psychology as a whole, namely that many of the subdisciplines tend to work in parallel and not together. There is little crossing over from one subfield to another. This lack of articulation between the fields of community and organizational psychology represents a major limiting condition to develop a substantive basis for the field of consultation.

On a more positive note, psychologists (more than nurses, psychiatrists, and social workers) are interested in designing and evaluating community-based prevention programs, and have been invested in perceiving mental health consultation as a pivotal defining professional role, i.e., providing indirect services through a consultee to a client, thereby increasing the radiating (preventive) effects of the service. To the extent that community psychologists have identified consultation as a primary professional role, it is likely that more research and theory can be developed to evaluate the impact of consultation as a preventive service. Psychologists also seem to enjoy the opportunity to integrate their professional skills and training with their political philosophies and preferences. Community consulting makes it possible to be a competent professional while at the same time being true to one's personal values when those personal values focus on meeting the needs of clients of low social status or working toward systemic organizational change. There is a potential for

psychologists to make a contribution regarding the practice of consultation as a preventive service, particularly if consultation techniques can illustrate indirect effects.

Close to the issue of integrating professional roles and competencies is the issue of empowerment. What underlies the interest of a key segment of psychologists who work in prevention is the opportunity to do consultation so that the consultee organization that lacks resources can become more resourceful and acquire social influence as well as funds. This difficult challenge of staying at the consultant task so that the consultant is not co-opted continues to make consultation an attractive and compelling challenge for prevention work.

Yet the challenge is certainly difficult, if not awesome, as Jane Conoley has described. While there is a steady flow of published material about consultation, the number of training programs and the number of psychologists who actively develop a community orientation to consultation are few. While there is much discussion in the literature on the prospects of consultation, the primary identity of the psychologist as someone engaged in the treatment of illness has not been affected. Jane Conoley aptly summarizes some of these factors, particularly the fact that theories of change have focused on the individual--i.e., the dominant value is to treat sick individuals, not to develop competent persons or communities. This fundamental paradigm shift demands persistence and resilience for the psychologist who wishes to create new hallmarks for professional practice. A key substantive resource for such shifts is the salience of how research and theory about the social environment can be related to consultation. Such additions can give equal attention to the qualities of the social setting where the consultee is embedded and to the qualities or characteristics of the individual consultee. Focusing on both the individual and the organizational level makes it possible for the psychologist to address conceptual issues that integrate the fields of organizational, social, and community psychology.

When psychologists invest in consultation they uncover an aspect of consultation work that is foreboding. The very nature of the consultation process puts the psychologist in a position of attempting to resolve conflict. This is often a novel experience for the professional psychologist since most psychological training does not elaborate various ways in which conflict plays a role in organizational change. Unless the clinical or community psychologist has had experience in small group processes, such a situation will present a new professional challenge.

Jane Conoley points out that, while there is much in the psychological literature about the practice of consultation,

discussions and evaluations of graduate training reveal few formal courses and few informal training opportunities available to doctoral students. The prospects of developing an educational culture for consultation as a primary professional role seem limited. This absence of an explicit commitment for formal training opportunities in consultation suggests that consultation techniques will continue to be a marginal activity within the profession. This is a major theme within the literature of each of the disciplines--i.e., that consultation is a secondary role or set of professional interests.

One of the major identifying activities of the psychologist is to conduct empirical research. In the case of consultation there have been some well-designed studies. However, as Jane Conoley points out, much of this published literature has focused upon evaluations related to the satisfaction of consultees with the consultation. There have been fewer examples of research attempting to identify whether the consultation activity does in fact initiate or produce any systemic effects--i.e., produce tangible results for the clients or the clients' organization.

Within the profession of psychology, consultation work will remain a marginal activity. Even so, useful insights will continue to be uncovered, particularly related to the processes of organizational and community change.

Social Work

With social work's longstanding tradition emphasizing community development, community organization, and social action, it is not surprising to learn that within the community mental health movement much consultation has been provided by social workers. The social work literature has focused on the processes, strategies, tactics, and techniques of consultation relating to knowledge about community organizing even though many of the consultants' activities have traditionally involved individual situations. The members of the other mental health professions may tend to forget that the social work profession invested in consulting roles such as the visiting teacher as early as the 1930s. The social work profession has also had a very strong commitment to strengthening interagency relationships over the past 40 years. In this sense the social work profession has championed efforts to improve the quality of service delivery, particularly encouraging members of different human service organizations to combine and integrate into political constituencies. Of the four mental health professions, social work has been the pioneer in advocating professionals to be more involved in action and, most importantly, encouraging connections being made

between the professional and political aspects of community development.

On the basis of the literature reviewed by John Goldmeier and Vince Mannino, it is difficult to discern a common theme in the variety of activities in which social workers engage. At this point there seems to be primarily a compelling need to clarify the various approaches that social work uses. Eventually a clearer theoretical orientation will evolve and from this a clearer set of techniques and value frameworks. Though prevention work has been identified as a goal in the profession, it is uncertain to what extent it is realized and to what extent consultation practice focuses upon organizational variables. Thus there seems to be a paradox within the role repertoire of the social work consultant. On the one hand there is little in the literature that suggests to the social worker active in clinical settings how to account for organizational variables. On the other hand, many social workers have been able to incorporate consultative activities directed at organizational issues. The social work profession is certainly an important resource for examining a variety of organizational settings and how these can impact on the consultants' role. If the consultant is working in a nursing home, for example, the nature of this social organization will certainly define how the consultation should be carried out and how the consultant can influence the organization that may be prescribing the consultant's behavior. Similarly, if the consultant is working in a public welfare facility, the consultant's role will be affected by this context.

Given the social status of social work within the mental health professions as primarily the purveyor of clinical services, it may be some time until its consultation activities can focus on system change. In this sense, the practice of consultation within social work seems to represent a general trend to provide technical assistance rather than focus upon organizational change.

In their chapter, John Goldmeier and Vince Mannino ask to what extent the social worker is a change agent in the sense of changing policy and revamping programs rather than a support facilitator, i.e., working with the consultee towards developing skills and increasing knowledge. There are few hints at this point how these preferences would be balanced in the future. Evidence so far seems to suggest both within the social work profession as well as from the other mental health disciplines that the dominant role of the social work consultant is still that of facilitator.

Conclusion

In each of the four major mental health professions, consultation is active yet marginal, talked about but not trained for, cited as a key hallmark of preventive and community mental health, but undeveloped as a generic role. This situation can be perceived as either positive or negative. It is positive in that there is plenty of activity; it is negative in that 20 years after the inception of the community mental health movement, there is as yet no solid structure for training consultation as a dominant role.

Nevertheless, there are opportunities for mental health professionals who wish to engage in community-based development to do so, provided their professional values are self-conscious and that they can pursue their chosen work without needing a sense that they are in the mainstream of their disciplines. For hardy professionals, consultation makes it possible to translate the concepts and views of their discipline into the framework of community work. In this very important sense consultation work is a valid ingredient within traditional roles of the mental health professions. As the mental health professionals continue to do consultation, there are opportunities for the practitioners to become more broadly educated. If the professions take seriously their role as active community resources, then all four of the disciplines need to accommodate professional training requirements to include consultation as a valid alternative role. Only then can the promise of community mental health be realized.

PART IV

ORGANIZATION AND PROCESS

CHAPTER 10

THE PROCESS OF CONSULTATION: CRITICAL ISSUES

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Introduction

Over the last two decades consultation has become an increasingly important means for meeting the mental health needs of individuals in communities. The term "consultation," however, means different things to different people and the range of activities incorporated in the actual consultation may vary quite dramatically.

On the one hand, a consultative exchange may simply be between a consultant and an individual or group of professional or paraprofessional caregivers about a problem with a client. Here the choice is often made to keep the consulting relationship relatively circumscribed, with contextual issues such as staff relations, organizational dynamics, and characteristics of the setting being viewed as extraneous and hence of no, or minimal, import to the consultation. On the other hand, the consultation may be defined in terms of the whole organization, in which case a much larger array of issues is treated as critical. Among these may be: (1) the incorporation of larger systems issues such as the purpose or function of the organization, the organization's internal dynamics, and the relationship between the organization and the community or environment in which it is embedded; (2) the consideration of the cross-cultural difference between the consultant and consultee represented in theoretical and world-view biases, interpersonal styles, and attitudes toward mental health issues; (3) the recognition of potential conflicts in values and norms when determining the feasibility of consultation; and (4) the examination of the motivations of consultant and consultee in the light of the prevailing social and political climate.

Over the last decade or so consultation in the mental health field has been expanded to incorporate many principles from the literature of organizational development, community psychology, and minority relations. Hence the current relevant literature is vast. For this reason, we can here present little more than a snapshot of the contemporary theory and practice about the processes involved in consultation. And this snapshot is, of course, just one moment in a historical evolution where future changes may be as dramatic as the changes identifiable in the past. For this reason,

the chapter will conclude with some of the prevalent thinking about the frontiers (i.e., emerging trends) in the consultation process.

Overarching Issues in the Consultation Process

Throughout this chapter we will use the term "process" frequently. It will be applied in three interrelated ways. At the most basic level, we will be referring to organizational processes operative within organized settings including interpersonal relationships, group dynamics, authority relations, and regulation of conflict between groups. We also will be using it to refer to consultation processes, i.e., the patterns of interaction involved in the exchanges between the consultant and the consultee systems. Clearly, on many occasions the organizational processes will influence the prevailing consultation processes and vice versa. For example, if the client organization is embroiled in racial conflict, it is most likely that the racial tension within the organization will influence how the consultant and consultee systems interact with each other, especially if an exclusively white consultant group is working with a racially mixed group of consultees. In this example, it is self-evident that the organizational processes and the consultation processes will become quickly intermeshed.

The third type of process involves interactions within the consultant system. In the case of an individual consultant, this may include the consultant's own inner conflicts about working with this particular system, any ambivalence about whether consultation will be helpful, or the unexplored biases being brought to bear in exchanges with the consultee. If the consultant system is a group or an organization, then its own internal group and organizational dynamics may constitute the "within-consultant" processes.

In the consultation relationship all three of the above types of processes will be operative. In this chapter when we use the generic term "process" we are referring to the interplay of all three of these. When we specifically mean one type of process as opposed to another, we will specify the term "organizational processes," "consultation processes," or "within-consultant processes."

Before discussing the key stages in the consultation process it is important to highlight that there are certain skills and awarenesses a consultant needs to possess. First, consultants need to be self-aware, attuned to their own feelings, thoughts, behaviors, and impacts on others (Gallessich 1982). They need to be firmly grounded in their own personhood to deal with the many unknown political, psychological, and social forces at work in organizations

(Goodstein 1978; O'Neill and Trickett 1982; Plog and Ahmed 1977). Second, consultants need to be clear about their own values, motivations, and theoretical biases (Argyris 1970; Cherniss 1976; Gallessich 1982; Steele 1975; Lewicki and Alderfer 1973) and to be willing to confront the tensions represented by their differences with consultees (Alderfer et al., forthcoming). Flight from these differences undermine the consultation relationship while their acknowledgment can be a constructive stimulus for change (Glidewell 1959). Third, consultants need to be open to learning and courageous enough to venture into new areas of growth (Alderfer and Brown 1975) while striving for a balance between the extremes of doing only what they know well, and doing more than they know how (Steele 1975).

From an external perspective, consultants need an awareness of the multiple groups they may represent in the mind of the consultee. Organizational group memberships (such as professional identification, political affiliation, "home" institution, status within that institution) and identity group memberships (such as age, gender, and race) can be powerful determiners of how the consultee and the consultant respond to each other (Alderfer and Smith 1982). These differences can provide much of the richness of the exchanges in consultation or, if ignored, can undermine the consultation process.

The degree to which writers and practitioners in the field have addressed these issues is varied. One area which has received attention is that of professional identification (Caplan 1970; Meyers et al. 1979; Plog and Ahmed 1977). In a very thoughtful and sensitive discussion of his consultative work with the bishop of an Episcopal church, Caplan described how each party had two very salient group identities which were the material for mutual projections: their profession and their religion. Caplan, a Jewish psychiatrist, felt uncertain about interacting with a man who seemed to live close to a "foreign" God. The bishop's view of Caplan was colored by myths about the omnipotence of doctors and the magical ability of psychiatrists. Their mutual willingness to explore these prejudices and fears built for them a strong, lasting, and rewarding consultative relationship.

The consultant's affiliation with a home institution is salient in consultation (Argyris 1970; Caplan 1970; Goodstein 1978; Werner 1978). When consultants act as representatives of their agency, for example, they must hold values that are congruent with those held by the agency they represent (Lippitt and Lippitt 1978). In addition, when developing a consultative relationship with an external setting, the consultant is not simply negotiating a relationship with a consultee or group of consultees, but between two institutions (Mann 1978). Hence, awareness of the

history of how these institutions view one another, as well as their respective positions in the larger community, is necessary.

The impact of racial differences in consultation has been inadequately explored, despite the fact that race is one of the most salient group identities affecting relationships. The lack of attention to racial dynamics in consultation is indicative of a pervasive tradition of white, male social science investigators either ignoring or acting out their group biases in their research work (Alderfer 1982; Boykin et al. 1979). An example of the findings in the few cases where race has been examined is the observation (reported by Gibbs 1980) that white consultees working with black consultants were more task focused and more oriented towards performance whereas black consultees working with the same consultants were more concerned with interpersonal competence.

Consultations which span such cultural or subcultural boundaries are very complex, but their very complexity makes boldly apparent the differences between consultant, consultee, and client. Similar differences are potentially present in all consultative interactions, though their bases may reside more in contrasting world views or research orientations rather than ethnicity. Hence, while ethnic dynamics provide insight into these differences in perhaps more than usually vivid form, subtle, easily masked, and unattended differences are likely to affect all consultative relationships. For example, Kahn et al. (1975) reported on a university-based group of consultants working in a community health center serving the Papago Indian tribe. They highlighted how easily messages may be misconstrued due to fundamental cultural differences in world view, language, societal implications of mental illness, and the verbal and nonverbal ways of communicating respect, deference, warmth, anger, and other emotions. In another cross-cultural consultation, Laosa, Burstein, and Martin (1975) discussed issues of the Chicano community with sensitivity. However, they did not report on how these cultural differences between the consultant and the consultees affected the actual process of consultation. The consultation project fell far short of its original goals. While the authors do not explore the links between the shortcomings of their intervention and their failure to explore cultural differences in the consultation, one can speculate on the extent to which this obstructed their effort.

The general literature on gender dynamics in organizations (Kanter 1977; Mayes 1979) suggests significant problems of stereotypical thinking confronting women who are in positions of power or who attempt significant interventions, yet research on mental health consultation has rarely explored this issue. One exception which illustrates the complexity of this issue is seen in a report by Gallessich (1982), in which a consultative intervention was

threatened by sexual overtones in the relationship between a female consultant and a male consultee.

One limitation on our understanding of racial and gender dynamics is the societal tendency to avoid discussing them or to deny their existence. In informal collegial conversations it is sometimes acknowledged that consultations have been severely impaired by themes of sexual attraction that have been ignored, acknowledged but not discussed, or worse still, acted out and then avoided. For obvious reasons, it has been very difficult within current professional norms and publication practices to explore in a systematic way the impact of such emotionally charged dynamics as gender and race.

Stages in the Consultation Process

Having discussed the issues that seem relevant for each consultant in interacting with a consultee system, we turn now to the critical stages involved in consultation. The stages in consultation have been delineated by many authors (e.g., Caplan 1970; Gallessich 1982; Goodstein 1978; Lippitt and Lippitt 1978; Meyers et al. 1979). Despite some differences in terminology and emphasis, the key steps are similar: initial contact, entry, contracting, diagnosis, intervention, evaluation, and termination. In order to capture the consultation process on the written page, we present them as discrete and sequential. However, these steps often overlap and generally co-occur throughout the life of a consultation. For example, evaluation recurs throughout the other phases; conversely, the specific evaluation process contains many elements that may be thought of in terms of other stages (such as diagnosis and intervention). However, we can think of each phase as having primary objectives that determine its major thrust as well as secondary objectives that contain elements of other phases (Alderfer 1981).

Consultation can vary greatly along a number of dimensions, including how much of the system is involved, how specific or vague the problem definition is, how much contact occurs between consultant and client, and how systematic the intervention is designed to be. For example, one consultation scenario may involve a single consultant encountering a single consultee about a specific unambiguous problem with a client where the consultant has little or no interaction with the client. On the other hand, the consultation may involve a whole team that develops a long-term relationship with a group of consultees over difficulties in their work with a client system. The nature of the relationship between consultees and client may be a factor in the problem to be worked on. In fact, the consultee-client relationship may be the

reason consultation is necessary. Under these circumstances, significant contact with the client system may be necessary simply to formulate an appropriate way for the consultants to think about the work that must be undertaken.

In this chapter, we will discuss the stages represented in the more complex case described above. Although most consultations will not involve everything included in this broad picture, the processes involved in most consultations may be viewed as a subset of these more global dynamics.

In order to discuss the stages of consultation common to the various models of consultation we need a general framework. We are electing to use the concepts elaborated by open systems theory for this purpose (Rice 1963, 1969; Alderfer 1976; Katz and Kahn 1978). We make this choice for two reasons: (1) across the last two decades it has been the prevalent model for discussing organizational consultation with explicit and detailed attention paid to process issues; and (2) its broad concepts are able to incorporate a wide range of activities involved in the various mental health consultation models, be they expert advice offered in one-on-one situations, program development, or education and training.

What is meant by the term "open systems theory?" The key concept is that one must understand a system in terms of the interrelationships between its elements and the transactions it undertakes within the larger environment in which it is embedded. Since its internal elements are interdependent, changes in one component may produce changes in other interconnected components. In addition, it is dependent on the larger environment for resources, information, and feedback. Katz and Kahn (1978) define a system as a mechanism that imports some form of energetic input from the environment, which submits that input to some kind of transformation process, and which produces some kind of energetic output back to the environment.

This notion of open systems implies the existence of some boundary that differentiates the system from the larger environment in which it is embedded. Boundaries vary in degree of rigidity and permeability. Boundaries which are rigid and impermeable create a closed system in which all transactions must take place within the system with minimal or no transactions with the external environment. On the other hand, an open system has fluid and permeable boundaries with respect to the external environment. The degree of rigidity and permeability represent critical concepts for the processes of consultation which open systems theory highlights. For a fuller elaboration of the principles of systems theory, see Katz and Kahn (1978) and Rice (1969).

When a consultation is undertaken, the boundaries of the primary system are opened up and something is imported into that system (the consultant, a new person, may bring new expertise, new knowledge, new procedures). This creates, at the very least, a temporary disequilibrium in the internal operation of that system, thereby providing an opportunity for change. The mere opening of the system boundaries for the purpose of the consultation may, in some cases, constitute a significant intervention in itself. However, usually the boundaries of a system are sufficiently resilient to return to their former condition once the temporary disturbance provoked by the presence of an outside consultant has passed. Hence the impact of the consultation usually rests on what remains altered in the system after the consultation has concluded.

Another valuable concept that we will use throughout this discussion about the processes of consultation is the phenomenon of "framing." By this we mean the particular conceptual context or world view used to describe and understand human actions by various members in a system. For example, a conflict between a female health worker and a male administrator may be "framed" by a consultant as a problem in their interpersonal relationship. This frame may lead to the consultation focusing on the specific interaction of the two individuals. However, this same exchange may be seen in intergroup terms. The conflict may be viewed as an enactment of gender dynamics or different professional identifications (health administrator versus clinician) or authority dynamics (superior administrator with subordinate clinician). Framing the conflict in intergroup terms entertains the possibility that any man and any woman in this position would become trapped in the same gender dynamics, or any administrator and any clinician (regardless of gender) would become similarly embroiled in conflicts created by professional and role differences, or any superior-subordinate pair in this set of authority relations would struggle in this manner because of the power differentials in this organization. Such an intergroup framing may lead the consultant to work primarily with the intergroup relations deemed critical, under the hypothesis that the original conflict patterns expressed by the two individuals may be changed only when the larger issues have been addressed.

One of the key contributions of systems theory is the development of a way to think about multiple levels of analysis. With every set of interactions, explanations may be sought at any number of levels of analysis--such as intrapersonal, interpersonal, intragroup, intergroup, and intraorganization. There is no a priori right answer as to which level of analysis should be chosen. However, the type of understanding available to the consultant will depend, in large part, on the frame chosen through which to

examine the phenomenon. How the problem becomes framed will predetermine the type of intervention seen as appropriate. Of course, the real wrinkle about the framing issue is that there is no such thing as just one frame. Since every organization is made up of multiple realities, or frames (Berger and Luckman 1967; Schutz 1970; Smith 1982a), the very existence of multiple frames is, in large part, what gives a system its complexity.

Throughout this chapter we will use the concepts and language of systems theory and framing to discuss the consultation process. We do this because it gives a common framework that enables us to highlight a diversity of consultation processes.

Entry and Contracting

The beginning of a consultation usually involves crossing a boundary in one of three ways: (1) the consultant is approached by a consultee for help either of a general nature or on a specific problem; (2) the consultant approaches a consultee system to offer services either because of a consultant's need for new clients or the desire to work within a particular organization or community; or (3) a third party, aware of the needs of the consultee system, brokers a relationship between consultant and consultee systems (Lippitt and Lippitt 1978).

Who initiates contact usually reflects both the boundary conditions of the organization and who manages the external boundaries of the system. For example, 13 of 19 consultative interventions (reviewed by Gendreau and Andrews 1979) in correctional agencies were initiated primarily by the agency. This is congruent with our general knowledge that such systems have very rigid boundaries that are highly regulated by the agency. On the other hand, some community-based systems may have boundaries that are very diffuse, difficult to identify, and easily crossed. In some instances, these boundaries are so difficult to identify that the consultant has to work on creating external system boundaries simply for the purpose of negotiating a contract in order to give legitimacy to the proposed consultation. If a procedure has to be developed to negotiate boundary crossings before the consultation can even commence, then the act of establishing contact alone constitutes a nontrivial intervention. Highly bounded systems usually make the first overture to the consultant, whereas with underbounded systems, the consultant is as likely to take the first initiatives.

Entry itself is a very complex process. How it is undertaken will powerfully influence the success of later interventions. At the metaphoric level entry implies finding the "doorway" into the

system. But it involves much more. It means watching out for false doorways, finding concealed passages, clearing out the debris which blocks some of the entrances, and trying to make sense of why the consultee might be setting up these particular roadblocks to entry.

The degree of boundedness of the consultee system reveals a great deal both about the system as a whole and the type of processes the consultant can expect to be operative during entry as well as during the consultation itself. For example, there are marked differences between systems that are overbounded and those that are underbounded. Alderfer (1981) indicates that overbounded systems tend to have clear goals; be monolithic in their authority relations; be precise, detailed, and restrictive in role definitions; and be constrained and blocked in human energy. On the other hand, underbounded systems tend to have unclear goals, have multiple and competing authority structures, be imprecise and have inadequate connections among roles, and find difficulty in harnessing human energy.

At a conceptual level, the function of entry is to assess system boundaries to find out whether the consultee system and the consultants can cooperate. On the basis of this assessment, efforts are made to adjust system boundaries in such a way that the consultation may proceed. This, in systems terms, is the process of developing a contract with the consultee system. This process will depend greatly on how tightly bounded the two systems are, and how the boundaries of the consultant and consultee systems are regulated. Some systems have very strong, impermeable boundaries (Alderfer 1976). This may be appropriate for a military unit under combat conditions but very inappropriate for a support group of clinicians in a psychiatric hospital. Thus certain boundary conditions may be necessary for one set of tasks but inappropriate for another set.

It is not uncommon to discover that the boundary conditions are inappropriate for the tasks required in order for the consultation to be successful. If the boundaries are very rigid and impermeable, certain internal organizational processes may be operative that are likely to influence the process of consultation in particular ways. Under these conditions, simply gaining entry may demand all the resources the consultant has reserved for the entire intervention. On the other hand, where boundaries are permeable and fluid, the problem is quite different. Entry per se may be easy, yet it may be very hard to identify what parts of the system the consultant has gained access to and what parts have been overlooked or the consultant sees as irrelevant.

This suggests that the entry tasks facing consultants differ in these contrasting situations. In systems that are well organized, entry at one point, especially if that level has appropriate authority, may facilitate adequate access to the whole system. In under-organized systems, or ones where factions are highly polarized, it may be necessary to use multiple entry strategies (Lewicki and Alderfer 1973). In systems where there is an inadequate authority system, entry may be a never-ending process. This is the antithesis of the overbounded situation where once the authorities have agreed to the consultation, all subordinate units may be required to participate whether they want to or not. Hence, in overbounded systems, the entry process must incorporate the granting of legitimacy for units of the systems not to participate if they so wish. Otherwise the consultation will be limited by the dynamics of implied coercion.

Given a body of literature about the relationship between boundary conditions and the internal life of a system, the consultant can use entry experiences as a basis for formulating hypotheses that can be explored throughout the diagnostic and intervention phases. This process of generating hypotheses early in the consultation provides a necessary frame for the whole of the consultant-consultee relationship. It sets in place the logic that experiences within the organization may have multiple meanings and that it is hence critical to frame issues in ways that enable multiple interpretations to coexist. This step helps overcome the type of epistemological blind spot that would catapult the consultant and consultee towards inappropriate interventions based on a lack of appreciation of multiple organizational realities.

The entry process also provides the consultee system with data about the consultant or team. How the consultants behave during this time may reveal a great deal about their processes. For example, consultants may claim that full, collaborative participation by all levels of the consultee system is important, yet propose an entry strategy which does not give low-powered groups in the system full decisionmaking rights on whether they wish to participate. Or the consultant may affirm the value of cultural diversity, yet shrink from the first sign of conflict between consultant and consultee systems based on issues of cultural diversity. These incongruities communicate powerfully to the consultee system the struggles and ambivalence in the consultants. These may be due exclusively to internal processes that consultants bring to the consultation or they may mirror ambivalences of the consultee system. We will discuss this further in the section on parallel processes later in this chapter.

No consultation is apolitical. Groups inside the consultee system will expect the consultant to take sides (Becker 1967), and

with whom the consultant becomes identified is critical. The part of the consultee system responsible for inviting the consultant in may have very different, even unconscious, agenda than those evident on the surface. This request for help may in fact be a way to appease one element of the system, to catalyze a slowly forming power coalition, or to throw fuel onto the smoldering embers of "potential rebellion." Thus the consultant must uncover early the potential political traps into which the consultant-consultee relationship may eventually fall or be pushed. For this reason, it is critical to build a support system of credibility across parts of the system that are in conflict (Broskowski 1978; Neely 1974).

The consultant needs to be in a marginal position, enough inside to understand what's going on and enough outside to be able to bring a fresh vantage point to each critical exchange (Smith 1976; Alderfer 1981). The marginality needs to be of two forms. On the one hand the consultant, by definition, is marginal to the system as a whole. This marginality needs to be maintained so that the consultant's independence is not threatened and so that the consultant will continually be able to articulate alternatives insiders overlook. The second type of marginality requires that the consultant not become overidentified with the interests of one or more groups in the system. For example, if workers see the consultant as employed by and invested in the interests of management, the value of any consultation on management-worker relations will be rather limited.

Two entry strategies that can help create a role of marginality are: (1) multiple entry--developing semiautonomous contracts with all critical levels of the system (Kahn and Mann 1952) and (2) building a liaison system--i.e., developing a cross-sectional group through which insiders and outsiders collaborate on how entry, diagnosis, and intervention may be conducted (Alderfer and Smith 1982).

The primary diagnostic focus of the entry phase is to determine which parts of the system will be involved, how well the values of the consultant and consultee systems mesh, and what roles are to be undertaken by the various parties during the consultation. Hence the formal act of entry may be viewed as ended when an agreement is reached by all relevant parties that a consultation will be undertaken. This agreement--which can either be formally recorded or informally agreed to--should include statements about the following issues (Alderfer 1981; Blake and Mouton 1976; Gallessich 1982; Mann 1978):

1. General goals of consultation,
2. Overall time frame,

3. Consultant responsibilities (services, methods, time commitment, and evaluation),
4. Which units of the consultee system will participate,
5. Agency responsibilities (including payment of fees and other resources),
6. Consultant's boundaries (who and what will the consultant have access to, conditions for bringing in other consultants, and confidentiality rules for all information),
7. Arrangements for periodic review and evaluation of both parties' input including explicit reference to the right of either the consultant or consultee to terminate the consultation if progress is unsatisfactory, and
8. Possibilities for renegotiating elements of the contract if later information indicates the value of taking different directions than those stipulated.

This last issue is important because the contracting process takes place while there is still much ambiguity and at a point where neither party really knows enough to formulate a contract which could cover all contingencies. Numerous writers have argued for some type of flexible contract that includes a clause for repeated negotiation and review of the process (Blake and Mouton 1976; Gallessich 1982; Goodstein 1978; Mann 1978; Meyers 1979; O'Neill and Trickett 1982). Despite this, most case studies fail to even report the agreed contract, let alone the process by which it was reached.

The process of consultation may involve soliciting information beyond what is publicly available, thereby raising questions of confidentiality. Virtually all professions (e.g., law, medicine, and clergy) have traditions of confidential relations. In consultation, confidentiality is critical, but it may be complex and hence must be addressed specifically. In the case of one consultant with one consultee discussing the case of one client, fairly strong norms of client confidentiality have been developed, though even these rules do not cover all contingencies (see Snow and Gersick, chapter 14 in this volume, for a discussion of complexities even in this instance).

However, when the system at large is included, additional complexities arise. The consultant may have to process data from multiple sources where it is difficult during feedback and intervention stages to address what needs to be dealt with while keeping everyone's confidences. This involves developing methods for clustering data and formulating concepts at a global level so that individuals are protected, an easy task where data concerning 20 people can be averaged. But in situations, for example, where critical data about authority relations surface which focus on the one person at the top, the situation is much more complex,

especially if information derived alone from that top individual is necessary to create a full picture. Since there is only one top individual, relevant data from the authority figure cannot be averaged. Therefore, the identity of the top individual cannot be protected using the same methods as with lower members of the organization. This type of a situation is not simple and should be addressed explicitly during the contracting process to avoid creating false expectations and possible pitfalls.

Clearly, there are limits to the confidentiality the consultant can offer. For example, under the law, the consultant does not have the confidentiality protections of a lawyer. Hence if the consultee reveals to the consultant information that involves illegalities (for example, malpractice by other professionals towards a mental health client), this "confidentiality agreement" may not hold up in a court of law. Consultants need to be careful to make this clear in advance.

Data Gathering and Diagnosis

It is tempting to think of the key stage of consultation as the implementation of a discrete intervention in the client system (e.g., clinical advice, a program of behavioral change, the instituting of new organizational procedures, or the development of a program to fill some special need). An open systems perspective, however, views consultation as a much more cyclical and evolutionary process of constant movement from hypothesis generation to data gathering, analysis, feedback, goal setting, strategy development, implementation, evaluation, and then back to hypothesis generation. The whole cycle may be repeated again and again, constantly challenging and refining one's understanding of the system (Gallessich 1982). From this perspective, diagnosis not only involves the uncovering of relevant data, but exploring the new data created by a shared consultant-consultee experience in the previous intervention cycle.

In this regard, the consultation process often involves research methods that include creating new data that may reveal critical dynamics relevant to the diagnostic tasks of the consultant. Consider, for example, a group interview consisting of representatives from several work groups that have interlocking functions but who, for whatever reason, do not interact very much. Before the group interview each representative may believe everyone sees the relevant work functions in similar terms. However, during the interview it becomes evident that there are many incongruities in these expectations. The surfacing of these

incongruities may involve creating "new" data for these participating members, placing into shared experience that which was previously idiosyncratic.

A variety of data-gathering methods are available to the diagnostician:

1. Unstructured observations,
2. Individual interviews,
3. Group interviews,
4. Structured observations,
5. Questionnaires, ideally with content developed from observations and interviews, and
6. Perusal of archival documents.

Since data gathering affects the relationship of the consultant and consultee system, the choices of methods should both maximize the benefit to this relationship and throw light on increasingly precise hypotheses about system dynamics.

In this spirit, Alderfer (1980) suggests the following temporal ordering of methods. Unstructured observation is minimally demanding and hence can be commenced at initial contact and be carried to the end of the consultation without hindering relationships. Individual interviews have the benefit of helping build relationships, if they are conducted competently, and they can be tailored to the specific experiences of organizational members. In contrast, administering questionnaires creates an impersonal, unilateral, and monotonous strain in the consultant-consultee relationship. While survey data is more systematic and more easily coded, surveys should be used only after good relationships have been established if solid data are to be obtained.

Group interviews are difficult to conduct and, depending on who is assembled, may prove to be either explosive or exhaustingly sterile. The choices of who to assemble range from interviewing all or part of established groups to interviewing representatives from several groups. What members reveal in a group interview will be largely influenced by its design. For example, an interview about racial dynamics conducted by two white consultants with an all-white group would be a radically different event than if an all-black group were assembled or if there were one black and one white interviewer with a group having equal numbers of black and white organizational members.

The boundary condition of the system may also shape the data-gathering methods to be chosen. For example, members of underbounded systems may be difficult to locate and may not understand the importance of the information they possess. In

overbounded systems, members are easier to locate but often overestimate the importance or uniqueness of "their" information.

Of the studies reviewed for this chapter, several features of data gathering were found in the best consultations: (1) organizational members, in conjunction with the consultants, were active in gathering data (e.g., Broskowski 1978); (2) data were sought from multiple sources and by multiple methods (e.g., Kelman and Wolff 1976); (3) methods were specifically tailored to the particular situation (e.g., Pargament 1977); and (4) data from organizational failures as well as successes were considered (e.g., Mann 1978). The most overwhelming observation of this review concerning data gathering was how few researchers said anything meaningful about what data they gathered and why, what constraints or investigatory philosophies shaped their choices, or how they determined the accuracy of their judgments.

Most articles reviewed were even more silent on how data were analyzed and how sense was made of the experiences recorded. Rarely were data examined from a hypothesis-testing frame. Most investigators took the approach that the system had to be understood intuitively and in terms of its own unique character. Qualitative data were mostly used, but few systematized techniques were adopted to link these data with the theory underlying the consultation.

The major premise of these investigations was that data were necessary to inform the consultant about appropriate organizational action in the particular, rather than the general, case. Hence, the major analytic technique involved collaborating with organizational members to make sense of the data. This collaborative process, usually consisting of some form of feedback, needs to be conducted in a way that enables the consultee system to "own" what it is finding out about itself. For this reason, Alderfer (1980) argues that qualitative and quantitative data have compensating advantages and disadvantages. With qualitative data, consultee members are encouraged to search for their own explanations, whereas with quantitative data, the data themselves are most likely to shape conclusions about the system. Thus qualitative data are more conducive to a participatory process of data analysis, leading to consensual validation, whereas quantitative data treat validity as a more objective, analytic endeavor.

The format for feedback must be shaped by the degree of conflict likely to be provoked by the data. Hence the content of the feedback (i.e., what is to be presented) needs to be meshed with the process of feedback (i.e., to whom, when, and how it is to be presented) in such a way that will: (1) enhance the collaborative relationship of consultant and consultee systems, (2) promote

the system's understanding of its own dynamics, and (3) lead to informed choices about appropriate interventions.

Within the general field of consultation about organizational processes, one familiar design to provide feedback is the "family group" (Bowers and Franklin 1972), consisting of a supervisor and immediate subordinates. This is appropriate for traditional structures that can be viewed as a series of interlocking family groups so long as authority relations are not punitive. With less traditional structures or where authority relations are strained, a peer group-intergroup design (Alderfer and Holbrook 1973) is more appropriate. In this design, peer groups explore these topics among themselves before entering into exchanges with hierarchical groups. This enables members to participate without the threat of being overpowered by authority figures. The peer group-intergroup design is thus most appropriate whenever ethnocentric (we-they) organizational dynamics are evident. The key is to counter the propensity to attribute primarily positive traits to one's own groups and negative traits to other groups. If peer groups can be steered away from exploring conflicts with external groups until internal processes have been explored, the likelihood that internal conflicts will be projected onto other groups is reduced (Alderfer 1980).

Intervention

The various organizational process issues previously described take different courses depending on the type of intervention the consultant chooses. The type of organizational and consultation process activated by the consultant is what is meant by the term "intervention."

No adequately comprehensive taxonomy of interventions has been developed although reviewers have attempted summaries using a variety of categories. Common among these have been: (1) the type of system receiving consultation (e.g., mental health, program, organizational, or community), (2) the philosophical model (e.g., education and training, clinical, mental health, behavioral, or organizational), (3) the actual dynamics of the consultation (e.g., process consultation, third-party intervention, team building, or survey feedback). It is not possible, in this chapter, to provide a comprehensive overview of contemporary consultations. Instead, this section consists of illustrations of the intervention methods commonly used by consultants.

Development of consultees' skills. Very often the consultant will focus primarily on skill development of consultees. Schein (1969) calls this the "purchase model." The consultee system

"buys" expert information or expert service. Typically this involves either individual or workshop training on the professional advances in such service fields as teaching or therapy (Alpert 1976; Mann 1978). It might, however, focus on themes such as how to avoid professional burnout by better personnel stress management (e.g., for teachers of the emotionally disturbed [Berlin 1978]), methods for establishing and running participatory ward meetings in treatment facilities (Drotar 1976), or how to conduct joint school-family conferences for creating collaborative treatment plans for special education students (Emiley et al. 1975).

Consultation on organizational processes. In contrast to the first category of developing consultees' skills, process consultation is more of a joint venture. The specific goals of intervention are developed collaboratively through the diagnostic phase, and the consultant's role is that of catalyst and facilitator in helping the consultee system determine its own problems and formulate appropriate action plans (e.g., Blanton and Alley 1978). In systems that are overbounded, such as the correctional facilities where Gendreau and Andrews (1979) worked, the catalytic function needs to be more extreme than in underbounded systems. Here the consultants acted in strong leadership roles, worked to involve staff, and then got staff to take over new functions, adopting behavior patterns that had been role modeled throughout the consultation.

Much process consultation work has focused on team building concerned with such topics as (1) changing interpersonal relationships that impair group effectiveness (Argyris 1962), (2) integrating new people into ongoing systems so that individuals' needs mesh with the organizational goals (Waker and White 1973), and (3) formulating and revising group norms to balance the emotional needs of group members with collective productivity. Team building is concerned with the participative assignment of roles, the creation of an accepting climate so that groupthink (Janis 1972) is avoided, the development of the self-reflective capacity of the group as a whole, and the affirmation of members' differences and similarities (Steele 1975).

Beyond team building is the task of system building. This includes making the procedures of the various parts of the system compatible (Meyers et al. 1979), overcoming ethnocentrism across a variety of organizational and identity groups (Alderfer and Smith 1982), developing communication channels through levels of the hierarchy with minimal distortion (Smith 1982a), creating appropriate problem-solving methods (Ruckhaber 1975), and bringing together the technical and human sides of an enterprise (Rice 1963; Miller and Rice 1967; Miller 1976).

There is a vast literature on consultation about the above organizational phenomena. Good overviews may be found in the following: (1) Addison-Wesley's series on organizational development, which presently consists of 13 volumes dealing with subjects such as the design of work (Hackman and Oldham 1980), the impact of organizational structures (Davis and Lawrence 1977), the influence of the physical setting (Steele 1977), the development of feedback systems (Nadler 1977), and third-party intervention (Walton 1969); (2) the Annual Review of Psychology (for example, Friedlander and Brown 1974; Alderfer 1977); and (3) the literature of organizational change (see Hornstein et al. 1971; Alderfer 1976; Beer 1980; and Goodman and Associates 1982).

Program development. Systems often come to recognize that new functions must be incorporated into everyday organizational life. Typical of these are: (1) the provision of transitional care, such as social support for deinstitutionalized psychiatric patients (e.g., Carpenter 1978; Segal and Aviram 1976), and counseling for individuals who have been laid off (Gore 1978; Katcher 1983); (2) explicit systems of socialization (Van Maanen 1976) and on-the-job training; (3) development of new procedures to deal with reward structures (such as collective bargaining), and worker participation (such as forming committees composed of management and union members to monitor the quality of work life) (Dachler and Wilpert 1978; Goodman 1979); and (4) introduction of self-government systems in facilities such as psychiatric hospitals and prisons (Gluckstern and Packard 1977). In program development work it is essential to: (1) tie the new procedures to what is currently practiced, (2) set in place the resources necessary to sustain it after the fresh blush of excitement about innovation has passed, (3) elaborate ways to confront conflict (Sarason 1972), and (4) determine when the new program has outlived its usefulness.

Linkage between the organization and the environment. A major task of most organizations is relating to other organizations. This may entail relations with overview agencies such as the State mental health bureaucracy that oversees a particular treatment center, or a board of education that has administrative and policy control over a school. It may involve relationships among organizations sharing lateral responsibilities such as a governmental welfare system, a health care program, and an employment agency each of which, for lack of coordination, may have administrative procedures that constantly double-bind the individual who needs simultaneous help from each of them.

In these situations, consultants have two potential roles: (1) as advocate for the interests of an agency in its interaction with other organizations (such as an innovative school dealing with a conservative educational hierarchy [Sarason 1982]) or as advocate

for an individual or a disenfranchised group (Neely 1974) and (2) as a bridge builder between organizations (Kahn et al. 1975).

In the advocacy role the consultant needs to take on, as it were, the interests of the individual, group, or organization for which the consultant is working. The consultant then presents the relevant concerns in the most palatable way to those whose actions have thwarted the client's interests, thereby creating the need for advocacy in the first place. In the role of bridge builder, the consultant must develop relationships so that the concerns of all parties are kept preeminent. The focus here is the relationship between the organizations, not the organizations themselves.

Another type of consultation work is done with systems whose primary function is one of liaison. Typical of these systems are the police who are expected to control crowds during demonstrations, protect the property interests of the community, regulate the practice of such illicit industries as drugs and gambling, intervene effectively in domestic violence, and perform a host of other mediating functions. This is a whole profession caught in the middle, whose very function leaves them in a position where others are dumping projected emotions on them. However, in order to work effectively, the police must not take on these projections. For example, if they develop negative attitudes towards women demonstrating against nuclear defense systems, minority groups such as the Cubans in Florida, or gays, their role as mediators will be severely undermined. Members of such agencies need help to collectively empty themselves, as it were, of the stereotyped negative affect they absorb from their work in the community. Here the consultation work is like systems therapy (Gardner and Veno 1976).

Summary. The concepts of systems theory can provide a useful frame for understanding the key processes involved in the consultation intervention. In a very fundamental way, all interventions alter the boundary system of the host environment. This may be focused at the external interface or in the internal processes. It may be manifested at the individual, the interpersonal, the group, or the intergroup level. It may be observed in the explicit, public, task domains or in the more subtle, covert, unconscious domains (Rice 1969). Whatever the focus, theoretically the process is the same--i.e., working out a way to realign parts of the system to operate more congruently with other parts. This may entail developing new internal methods of integration to deal with the differentiations triggered by the external environment (Lawrence and Lorsch 1969) or forming new systems of regulation to keep the chaos of one part from spilling over into other parts. It is a process requiring constant fine tuning, as necessary for an organization as a regular tuneup is for an automobile.

Evaluation

In the research literature reviewed for this chapter, evaluation is almost entirely ignored. Despite the recurrent calls for better evaluation of consultation, the accountability movement of the 1970s, and the efforts to develop better program evaluation techniques (Goldstein 1980), this remains one of the least considered phases in consultation.

Evaluation may be thought of in both outcome and process terms. Outcome measures vary from rigorous judgments of whether there was long-term maintenance of changes after the consultant left (Gendreau and Andrews 1979) to impressionistic attitudes of consultees towards the intervention (Gardner and Veno 1976). A systems approach emphasizes constant monitoring of every phase of the intervention throughout the consultation with the goal of detecting possible shortcomings early so that changes can be made in the evolution of the intervention plans.

This orientation makes evaluation an integral part of the consultant-consultee relationship and equal in importance to the other stages of consultation. Specifically, the consultant and consultee need to regularly take time to review progress, actively seeking out data and perspectives that might lead them to correct or modify their course. In systems language, this means building in feedback loops that protect the consultant and consultee from merely operating within or creating realities based on self-fulfilling prophecies. If the consultation is being undertaken by a team and the consultee is a group rather than an individual, it may be helpful to create a liaison group made up of representatives of both the consultant and consultee systems. The task of the liaison group may include regulating the boundaries between the consultant team and the consultee's organization, managing power differences between consultant and organizational processes, monitoring affective patterns, correcting cognitive distortions, and making the consultation activity beneficial for the client system as well as the consultant and the consultee (Alderfer and Smith 1982).

The systems orientation underlying this chapter asserts that evaluation should include both process and outcome orientations. Regrettably, the consultation literature is silent on the key consultation processes involved specifically in the evaluation stage of consultation.

Termination

Ending the consultation is a very important process. In the language of systems theory, this is a time of major boundary reorganization. The systems built to facilitate the consultant-consultee relationship must now be delicately dismantled, but in a way that does not undermine the newly created (or finely tuned) boundary system. This is no simple task. Termination creates disequilibrium and often will prove to be the first major test of the resilience of patterns created via the consultation.

Termination occurs when either: (1) the goals of consultation are accomplished and the consultee can carry on alone, or (2) consultation has failed to meet its objectives but its continuation is determined not to be fruitful. The end of a consultant's involvement with a consultee organization should be anticipated and planned for long before the end. In fact, it should be discussed at entry. Two critical pretermination goals are the institutionalization of change (Goodstein 1978) and the transfer of full responsibility for the consultative program to the consultee organization (Gluckstern and Packard 1977; Lippitt and Lippitt 1978). Key phases in termination include: (1) ensuring that the critical resources are available for the ongoing work of the intervention, (2) transferring responsibilities and skills from the consultant to relevant individuals within the system, (3) exploring and affirming both the good and bad times for all parties during the consultation, and (4) outlining any future contact the consultant and consultee systems might have. Termination is an emotionally stressful time, especially if the relationship became a significant one, and these aspects of the consultation should be explicitly addressed by all parties. Not confronting the issues raised by termination may hinder further development of the consultee system and negate the positive contribution of the consultation.

Frontier Thinking About the Consultation Process

We began this chapter with an acknowledgment that consultation is in the middle of some rather significant changes both in theory and practice. We will discuss briefly three of the key trends that have surfaced over the last few years. These were chosen because they have been developing in parallel, though without significant mutual influence, in both the therapeutic and organizational domains.

The first trend is the emerging distinction between change that is at the level of essence rather than form. The psycholinguists call this distinction "deep structure" versus "surface structure." Watzlawick, Weakland, and Fisch (1974) of the

therapeutic world refer to it as "second-order" versus "first-order" change. Argyris (1982) of the organizational world labels it "double-loop" versus "single-loop" learning. And the cyberneticists call it "morphogenic" versus "morphostatic" change (Wilden 1980).

The second trend involves the concept of parallel processes. In therapy this has involved the broadening of the transference/countertransference phenomenon to the level where what occurs between a supervisor and a therapist may be viewed as a parallel "playing out" of dynamics operative in the client-therapist relationship. In the organizational domain, this may be illustrated by the tendency for conflicts among heads of corporate divisions to be enacted by their subordinate groups. The conflict becomes expressed at a level far away from its source and in a form that makes it difficult to untangle whose conflict it really is.

The third trend is the broadening of general systems theory and the development of what is now called "cybernetics II." This body of thought calls into question the time-honored concepts of stability through homeostatic/equilibrium processes and the social Darwinian idea of survival of the fittest. Instead it suggests the notion of order through fluctuation (Prigogine 1976) and the survival of the symbiotic (Jantsch 1980). Early attempts have been made by Dell and Goolishian (1981) to apply these concepts in family therapy and by Smith (1984) in examining developmental processes in a new organization.

We will discuss each of these trends briefly here.

Second-Order Change

The crux of the "second-order" versus "first-order" change issue is whether, once change has occurred, the system will remain changed or will revert to its earlier condition. This is similar to natural evolution where the change is of a form that penetrates so deeply into the "genetic code" that all future generations acquire and reflect those changes (Smith 1982b). Argyris (1982) frames the issue as follows: Systems make mistakes. Their efforts to detect and correct the error may or may not question the underlying governing rules of the system. When these underlying rules are not questioned the learning is called "single-loop." In contrast, when such rules are questioned, so-called "double-loop" learning may occur. To illustrate with an example from cybernetics, a thermostat programmed to turn itself on or off depending on the temperature demonstrates single-loop learning while a thermostat that could ask itself why it was set at a particular temperature demonstrates a double-loop.

The key issue for our purposes here is to highlight that a consultation designed to produce a lasting change in the organization must focus on the underlying rules that govern the system. For varied reasons, the governing rules of a system are usually not consciously articulated while they are being used. That is why the consultant's alternate logic and "frame" are necessary for the system to get a perspective on its own logic, its own governing patterns, its own deep structures. For the system needs a way to develop a perspective on itself while it continues to be itself. This is the collective equivalent of a self-observing ego, an essential characteristic for any system to be able to learn about itself from its own experience. Assisting a system to develop ways to self-reflect is a major goal of consultation. Hence, the consultant needs to engage in processes which support, rather than undermine, that development.

Parallel Processes

Parallel processes are defined as the tendency for two or more systems (individuals or groups) that have significant and developing relations with each other to show similar affect, behavior, and cognition (Alderfer et al., forthcoming). Parallel processes are operative in many different types of consultant-consultee relationships. They have been observed in the supervision of psychotherapy where the relationship of the supervisor and the therapist may be a parallel playing out of the therapist-client relationship and vice versa (Searles 1955; Ekstein and Wallerstein 1958; Sachs and Shapiro 1976). If the supervisor attends closely to the aspects of the supervisory relationship, new insights as to what is occurring unconsciously in the therapeutic encounter may be opened up. This principle has been used very effectively by family therapists (Haley 1976; Hoffman 1981), who constantly look at the relationship of the co-therapists as a mirror in which covert family dynamics can be detected.

In the organizational field similar findings are reported by Smith and Crandell (1984) and Alderfer et al. (forthcoming). They note that the internal process of the consultant group often takes on the character of the system dynamics they are attempting to understand.

The concept of parallel processes has two powerful implications for the process of consultation. First, the consultant-consultee relationship should be structured to encourage systematic self- and other-scrutiny. Critical processes operating in the organization may be influencing the consultant-consultee relationship without their knowledge and, unless self-reflection is a shared value, the chances of detecting this and capitalizing on it

in a constructive way are low. Second, the converse is equally critical. Dynamics operative within the consultant team may cloud the consultant-consultee relationship and diminish the effectiveness of their work together. Thus, the theory of parallel processes postulates that in all probability at least some aspects of the consultant-consultee relationship mirror processes elsewhere in the organization.

Cybernetics II

General systems theory views fluctuations as disturbing the equilibrium, so if a system is to remain stable, fluctuations must be minimized. However, cybernetics II has challenged this "equilibrium principle," claiming that fluctuation is essential for the creation and maintenance of order and that, without it, order is destroyed (Prigogine 1976). This idea is counterintuitive and requires an understanding of the difference between resilience and stability. Holling (1976) defines stability as the capacity of a system "to return to an equilibrium state after a temporary disturbance; the more rapidly it returns and the less it fluctuates, the more stable it is" (p. 81). On the other hand, resilience is a measure of "the persistence of a system and of its ability to absorb change and maintain the same relationship" (p. 81) with other entities in its ecosystem. With these two concepts in place, it is possible to think of an entity becoming more unstable with large fluctuations, but, by surviving these fluctuations, becoming more resilient.

An example of how the stability and resilience perspectives provide different frames for consultative processes can be seen in considering what occurs at entry. More often than not, entry is filled with conflict. If this conflict is approached, explored, and allowed to be a legitimate part of the consultant-consultee interactions, then a relationship can be developed based on resilience rather than stability. While this makes the early phases of the consultation more turbulent and more complex, it forges a special type of understanding that can be invaluable in later stages where conflict and chaos can threaten to overwhelm the consultation.

Another key principle of cybernetics II is that, for a system to survive, it must pour energy into creating the kind of environment in which it can be nurtured and flourish. For a system to remain vital, it must be in constant discourse with both the internal elements of which it is made and the ecosystem in which it is embedded. This means that sometimes chaos in the internal relations of a system ends up being an expression of an ecological fluctuation that is necessary for the ecosystem to remain resilient over time as a thriving system.

Conclusion

The implications of these three frontier areas for the processes of consultation are substantial. Ten years from now a review such as this may well look radically different. For the consultant to be really helpful to a system, it may be necessary to focus on the governing rules of the system as opposed to the surface problems that trouble the consultee. This may mean that the processes of consultation will involve not only the relationship with the consultee, but also with the client system and other organizations with which the client organization is interdependent.

Further, the consultant may have to push the consultee system to spend a great deal of effort on monitoring its own internal processes to learn from and avoid the negative consequences of parallel processes operating in the consultant/consultee/client relationships. It may also prove necessary to create new technologies to enable organizations to develop a way to reflect on themselves and their relationships with other systems.

It may also be that the internal life of any system will have to be understood in terms of its place in a rapidly changing ecology, and that understanding the rules upon which the larger ecosystem operates may be preeminently critical for appreciating intraorganizational dynamics. This would mean that a great deal of the energy of a consultation dealing with internal organizational dynamics will have to be focused on assessing external dynamics such as the dominant patterns of interorganizational relations in the ecosystem, the impact of culture, and the way that global social change occurs.

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CHAPTER 11

TRAINING OF MENTAL HEALTH CONSULTANTS

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Training was unavailable and probably deemed unnecessary for the first mental health consultants; their qualifications came from years of experience and from their expertise in psychiatric specialty areas. Today, however, consultation usually requires unique knowledge and skills, and numerous training programs have evolved to equip mental health professionals with the needed competencies. This chapter reviews the major social, political, and technological forces shaping consultation practice and then traces their effects on developments in training.

Several dominant consulting models have emerged, and the earliest training programs prepared trainees with the unique competencies needed to specialize in only one of these consultation approaches. However, the lines separating these different models are becoming less distinct, and training programs now often include preparation for practice in several models. Moreover, trainers frequently emphasize generic knowledge and skills needed by all consultants.

Because of these trends, contemporary trainers have many options to consider when designing programs. The crucial questions trainers must raise--such as those related to goals, curriculums, and methods--are discussed, and alternative responses to these questions are reviewed. A major problem in making training decisions is the lack of adequate information concerning the roles and functions of consultants and the specific competencies needed by practitioners. Recommendations that would increase trainers' data base and guide the design and evaluation of training programs are outlined.

Environmental Determinants: Social and Political Context for the Development of Training

Consultation training, like consultation practice, is shaped by many environmental forces. Consumers' demands for services, the economic and political zeitgeist, professional traditions, and technological developments interact so as to encourage the development of certain training patterns and discourage the development

of others. These forces and their interactions, along with the implications for training, are in continual flux.

Consumer Demand

Consumers' views as to what services will or will not be useful are, of course, a primary determinant of professional practice and training. Certain consultative services, although potentially valuable to organizations, are rejected by their members. Consequently, training for these services, if it somehow emerges, is not likely to survive. To illustrate, many consultees prefer a traditional approach in which the consultant focuses on and diagnoses a third party—a patient, a client, or an organization. When a new consultant role that focused on consultees' skills and deficits first evolved, consultees' ambivalent reactions soon led to its abandonment (Levine and Levine 1970). Acceptance of this approach and subsequent institutionalization of training for it came slowly several decades later. Conversely, when the organization development (OD) approach appeared, consumers quickly popularized it; their enthusiasm spawned dozens of training programs geared to turn out OD practitioners. More recently, organizations are seeking more effective ways of utilizing and nurturing human resources; training especially designed to prepare consultants to work in this area are appearing.

The Economic and Political Zeitgeist

Political, cultural, and socioeconomic forces interact with consumer preferences to shape consultation practices and training. Results of epidemiological studies of mental illness in the 1950s aroused the entire nation. The incidence of mental disturbances was far greater than previously suspected. At the same time, disparities between the needs and the availability of traditional professional services led to a search for innovative approaches. One outcome was the institutionalization of mental health consultation, an indirect approach through which professionals increase the abilities of direct caregivers—such as teachers, nurses, and policemen—to prevent and ameliorate mental illness in the individuals with whom they work. But mental health consultation requires complex skills; hence a new type of consultation training was needed.

The Federal Government responded to this dilemma with strong support for mental health consultation training; this sanction was particularly evident in National Institute of Mental Health grants that favored the training programs that included preparation for mental health consultation. The concern for

greater social equality that dominated the 1960s affected consultation practice and training. Social change became a paramount goal; change-oriented consultation for the purpose of democratizing the workplace became popular. The same zeitgeist gave rise to training programs preparing community mental health professionals to increase the resources and opportunities available to disadvantaged individuals in our society. Recently, increasing conservatism and an economic recession are creating a frugal climate and heightening demands for accountability. Consequently, some consultation training includes preparation for program evaluation, for work with various mechanisms designed to cut mental and physical health care costs, and for the task of helping declining organizations cut back operations in as humane a fashion as possible.

Professional Traditions

Professional values and cultures also affect the development of consultation practice and training. Through their cherished traditions, conceptions as to their proper roles and functions, theoretical preferences, and assumptions as to the most effective intervention modalities, professional groups encourage certain forms of consultation practice and training and discourage others. In their infancies, all mental health professions assumed the traditional clinical consultation model of their parent, the medical profession (Brosin 1968). Only slowly have they accepted other modes.

Mental Health and Social Science Technology

Consultation practices and training are also influenced by whatever technological armament--theories, concepts, principles, skills, and treatment--is available. The earliest consultation practices and training programs were founded on psychoanalytic theory and intervention techniques (Caplan 1970). With the burgeoning of learning theory and research came new consulting tools and training programs to teach mental health professionals how to use them (Bergan 1977; Goodwin et al. 1971; Reppucci and Saunders 1974). Similarly, the emergence of a huge body of knowledge concerning the workplace legitimized the entry of mental health consultants into this domain where they now offer help in solving problems in such areas as morale, motivation, leadership, stress, and conflict. Numerous training programs equip mental health professionals for this type of organizational consultation.

These forces interact to popularize certain consultation models and deter the development of others. They determine what

competencies consultants need and the goals and curriculums of training programs. These forces also influence such training decisions as who will be trained, who will perform the training, and where and when training is to occur.

Dominant Training Models: A Developmental Perspective

Four major consultation training models have evolved. Each of these models responds to a unique set of environmental forces and, therefore, prepares trainees for distinctive roles and functions. In recent years, however, training programs often blend two or more approaches and prepare their graduates for multiple roles and functions.

Training for Clinical Approaches

The earliest model of mental health consultation followed the ancient medical practice in which a physician who is expert in a particular specialty area (the consultant) evaluates and advises another physician (the consultee) regarding one of the latter's patients or clients. In the mental health version of this model, the first consultants were psychiatrists; today consultants may also be social workers, psychologists, or nurses. The consultant examines a patient's mental or emotional functioning and gives the consultee (the referring physician or other professional) a diagnosis and recommendations for treatment. This form of consultation is variously referred to as clinical consultation, medical-model consultation, client-centered mental health consultation, consultant-liaison, and psychiatric liaison. It continues to be a basic role of clinicians (Allen 1981) and is widely practiced by consultants from all mental health professions. It is a routine practice in human services organizations (Caplan 1970; Drotar 1978; Hales and Fink 1982; Kaslow 1979; Pollack 1968; Mendel and Solomon 1968). It is also found in business and industrial organizations (Levinson 1968, 1978; Yeager 1982). In these settings the "patient" or client is often an entire organization or some part of it. The consultant, taking an expert role, examines and assesses the patient's health, interprets the findings, and presents a diagnosis and a set of recommendations to the consultee (an administrator, team, or supervisor) in a conference and a written report (Rieger 1977). The model assumes that the problem lies in the client and that the consultee can and will accept the consultant's diagnosis and recommendations.

What competencies are needed for practice in this model? Success depends not as much on specialized consultant training as

in years of experience and achievement of expertise in diagnosing and treating certain problems. However, the ability to communicate is often regarded as a key variable in effective consultation (Barnes et al. 1957; Brosin 1968; Garrick and Stotland 1982).

No training for this consultant role was considered necessary until a 1952 training conference sponsored by the American Psychiatric Association revealed the failure of residency programs to prepare trainees for preventative psychiatry (Whitehorn 1953). Trainers were encouraged to prepare residents to work with other professions and with lay representatives of community organizations. Following this conference, psychiatric residency programs began to include consultation training. Formal training for the practice of clinical consultation or psychiatric liaison is now available to trainees from all mental health professions in hospital and clinic settings. Surveys of clinical psychology internship programs indicate the majority offer training in clinical consultation (Gallessich 1984; Tuma and Schwartz 1978). Training for this model is occasionally found in educational settings and in other institutions such as public health facilities.

Descriptions of clinical consultation training programs have been provided by many trainers (Drotar 1978; Eaton et al. 1977; Houpt et al. 1977; Kimball 1975; McKegney and Weiner 1976; Schubert and McKegney 1976). The content is case-oriented but may include oral and written communication skills. Supervised experience is the common method, but lectures and readings may be included. For instance, trainees may study conceptual and practical guides for gathering and organizing data (Leigh and Reiser 1982) or for writing clinical reports (Garrick and Stotland 1982). Training for clinical consultation takes place in the final training phase--during residency or internship. This training model is most fully described in chapters by Abrahamson, Aldrich, and Mendel in *The Psychiatric Consultation* (Mendel and Solomon 1968) and in an article by Cabinet and Schubert (1981).

The clinical consultation training programs referred to above emphasize the more traditional form of this model in which the client is an individual for whom the consultee is responsible. Levinson (1968) describes a training program at the Menninger Foundation that prepares psychiatrists for the form of clinical consultation in which the organization itself is the client. His book *Organizational Diagnosis* (1972) also provides detailed guidelines for this approach.

Training for Consultee-Centered Approaches

In the 1950s nationwide concern over the high incidence of mental illness and the shortage of mental health professionals led to a paradigm shift. The newly popular consultee-centered consultation model was actually 30 years old, but until this time had been rejected by consumers and professionals alike. Theoretically elegant, this model promised to be a means of significantly ameliorating social problems. Often referred to as the mental health consultation model, it is a standard service in most human services organizations (Altrocchi 1972; Burkhart and King 1981; Caplan 1970; Lieber 1978; Rogawski 1979; Spielberger 1967).

Departing sharply from the goals and assumptions of the clinical model, the consultee-centered model seeks to increase consultees' competencies in preventing and treating mental illness and in promoting mental health. The consultant does not examine the client but instead relies on the consultee to identify and describe salient aspects of the client's problem.

Unlike the clinical model consultant, the mental health consultant does not seek to provide an expert diagnosis or set of recommendations. Instead, each case is viewed as a strategic point for enriching the consultee's knowledge and skills. The hope is that positive cognitive and affective changes will take place in the consultee. Consultants working in this model abandon the clinician's expert stance; interacting in a collaborative fashion, they share relevant concepts and techniques in case conferences. They also offer seminars and workshops to further demystify their expertise. The consultant then serves as resource person, educator, facilitator, and emotional supporter. The model assumes that the consultee lacks information or problem-solving skills or has emotional barriers that prevent effective work with certain clients. It also assumes that the consulting relationship can be a medium for effecting consultees' growth.

Since the success of this approach relies on good working relationships between consultants and consultees, it requires not only special expertise in the problems of the client population but expertise in building and maintaining effective peer relationships. An especially crucial skill is the ability to detect any emotional reactions that interfere with consultees' working relationships and to help them achieve healthier attitudes and relationships without moving out of the peer role into the more familiar role of therapist. Knowledge of the context in which the consultee works, including the organizational norms and values, is also an important competency. Clearly this model requires different and more extensive training for the consulting process than the clinical model.

By 1955 the Harvard School of Public Health offered postdoctoral training in consultee-centered mental health consultation to professionals from all mental health disciplines. This training model, with its emphasis on the delicate relationship skills needed for helping consultees grow, has been fully described by Caplan (1970). Preservice training soon followed the Harvard program; the University of Texas at Austin began offering consultation training to predoctoral students in clinical and school psychology in 1962 (Gallessich 1974; Iscoe et al. 1967). By 1969 the National Institute of Mental Health was funding 20 residency programs in community psychiatry, all of which included training for the consultee-centered approach (Gallessich 1982).

Today preparation for this model is found in many programs that train mental health professionals. Most training designs are derivatives of Caplan's prototypic program (Conoley 1981; Gallessich 1974; Hartsough 1972; Jacobson et al. 1983; Kaslow 1977, 1979; Lambert et al. 1975). The curriculum includes consultation theory and process (Beisser and Green 1972; Caplan 1970; Gallessich 1974; Lambert 1983). Social systems theories were included in Caplan's program and are still part of it in most training for this model (Broskowski et al. 1973; Jacobson et al. 1983). Methods include diadactic input, laboratory training, and supervised field experience. Training may be offered at any level—predoctoral, postdoctoral, inservice, and continuing education.

Many detailed accounts of this type of training are available. The predoctoral-level preparation in the school psychology training program at the University of California at Berkeley has been fully described (Lambert 1983; Lambert et al. 1975). The continuing education level training developed by Beisser and Green is detailed in their 1972 book. Inservice training programs are described by Broskowski, Khajavi, and Mehryar (1973) and by Jacobson and others (1983).

Training for Behavioral Approaches

With the growth of learning theory and the discovery of techniques that could change behavior, a new consultation approach quickly evolved. Mental health professionals began to use learning techniques to help key persons in organizations requiring high levels of conformity (such as certain educational and correctional institutions) modify their clients' behavior (Heller and Monahan 1977; Keller 1981; Tharp and Wetzel 1969). This consultative approach expanded to include theories and interventions from social learning (Bandura 1977), ecology (Winett 1980), and cognition (Mahoney and Thoresen 1974; Meichenbaum 1975). Behavioral consultation is now widely practiced, not only in human services

organizations, but in business and industrial organizations (Glenwick and Jason 1980; Huse 1975; O'Brien et al. 1982; Pedalino and Gamboa 1974). Learning theory assumes that all behavior is learned as a result of external reinforcement patterns. Behavior can then be changed by modifications of salient environmental reinforcers. The behavioral consultant views consultees as key sources of clients' reinforcements. The goal is to identify the behavioral objectives and analyze the relationship between these target behaviors and environmental contingencies; then a situation-specific treatment plan is formulated. Careful pretreatment and posttreatment measures are taken to monitor treatment effects. Behavioral consultants vary greatly in role and function. Some prefer to take a supervisory approach and monitor consultees' and clients' activities; others prefer to take educative or facilitative roles. Activities include analysis, treatment design and implementation, instruction, supervision, behavior rehearsal, and modeling. Consultants may also use visual imagery, self-talk, or other cognitive restructuring methods.

Competencies needed for this model depend on the consultant's goals and methods. However, knowledge of learning theory and techniques of behavioral modification is essential. For some behavioral approaches, skills in consultant-consultee interactions are important (Bergan 1977), and for many behavioral consultants, relationship skills are considered crucial (Kuehnel and Kuehnel 1983). Most reports of training for this model come from school psychology and community psychology training programs. Training began in the late 1960s and early 1970s (Goodwin et al. 1971; Bergan and Tombari 1976). The school psychology training program at the University of Arizona became the center of many developments in training for behavioral consultants. The community psychology training at Yale University also made substantial contributions to their preparation of behavioral consultants (Reppucci and Saunders 1974).

These programs usually place heavy emphasis on classical learning theories. They may also include social learning and cognitive theories as well as intervention principles and techniques based on these frameworks. Evaluation is an inherent part of the intervention and hence is an important training element. Relationship skills are included in the content of some programs (Kuehnel and Kuehnel 1983; Dorr 1978). Methods used by trainers include instruction, laboratory exercises, and supervised field experiences. Typically, training for this model takes place late in predoctoral training—either just prior to or during internship.

Many descriptions of this training model are found in the literature. Bergan (1977) and Bergan and Schnaps (1983) provide an especially detailed description of an approach that stresses

methods through which the consultant controls the process of eliciting diagnostic data and developing intervention plans. Kuehnel and Kuehnel (1983) outline a design that prepares consultants for a more facilitative and educative approach. Dorr (1978) describes a program in which students first work with animals in a traditional Skinner box, then move through carefully sequenced steps to field work with teachers.

Training for Organizational Approaches

The first consultants to organizations were not mental health professionals but scientific management experts whose goal was to help organizations increase their productivity by improving tools and technological processes. With the discovery in the 1930s that satisfying workers' social and psychological needs increases productivity, mental health professionals entered the arena of organizational consultation and a new paradigm appeared. The consultants brought with them a burgeoning body of knowledge regarding the effect of human variables such as morale, motivation, leadership style, social climate, and group processes on workers' mental health and productivity. A specialized form of organizational consultation, organization development, appeared in the 1950s; this approach includes a broad array of interventions aimed at systemic change, organizational renewal, and democratization of human relations. Today many varieties of organizational consultation are practiced in human services organizations and in business and industrial settings (Alderfer 1977; Argyris 1970; Burke 1980; Goodstein 1978; Likert and Likert 1976; Schein 1969; Schmuck et al. 1972; Steele 1975).

The conceptual bases and methods of organizational consultants vary greatly. Their theoretical framework may be psychodynamic, cognitive-behavioral, social-psychological, or ecological (Holahan 1977, 1978; Proshansky et al. 1976; Steele 1973). The focus may be on structure, environment, or technology; most often consultants from the mental health professions focus on human processes such as communications, decisionmaking, conflict, and team building. The consultant's role may be diagnostician, teacher-trainer, coach, action-researcher, or participant-observer; frequently, it is facilitator. The assumptions underlying this approach are varied. The fundamental one is that productivity can be increased through satisfying workers' psychosocial needs. Among the other assumptions are these: First, organizational problems can only be understood and solved through systems approaches that consider both internal and external environments. Second, organizations tend to stagnate over time; consequently, adaptive mechanisms are essential for continuing productivity.

The competencies needed for practice in this approach include theories for understanding organizational, group, and individual behavior and assessment and intervention skills for these domains (Goodstein 1978; Keys 1983; Lippitt and Lippitt 1978). Training for organizational consultation began and continues today in nontraditional settings such as the National Training Laboratories, the Organization Development Network, and University Associates. But the demand for training in this model is great, and opportunities are now available through courses in academic settings as well as through entire programs and departments (Campbell 1978). The content includes theories of organizational, group, and individual behavior; assessment principles and skills; intervention methods; evaluation and research skills; consulting theories and principles; and methods for leading laboratories and workshops. Methods include lectures, supervised placements, and laboratory training. Within universities, preparation for organizational consultation is usually located at the predoctoral level. But most training for this approach is found outside academic settings in nontraditional educational organizations and in programs offered by professional associations; in these sites, most trainees are at midway points in their careers. Typical university-based programs are described by Gallessich (1982) and Keys (1983). Benne, Bradford, and Gibb (1975) discuss various methods used by trainers in nontraditional settings.

Training for Multiple Approaches

Many programs prepare trainees for multiple approaches. For example, in a continuing education program, staff of a community mental health center are trained in consultee-centered, organizational, and ecological models (Jacobson et al. 1983). In a university-based program, Weinstein (1981) prepares clinical psychology students to use mental health, ecological, and organizational models to consult in schools. In a program combining academic and applied settings, Leonard (1979) offers training for several approaches including clinical, advocacy, ecosocial, and organizational models.

Training for Other Models

Training programs prepare mental health professionals for other approaches to consultation. Most university-based training programs include preparation for program evaluation consultation, a role through which consultants help agencies design, implement, and evaluate programs and other operations (Anderson and Ball 1978; Matuzek 1981; Perloff et al. 1976; Ziegenfuss and Lasky 1980). Among the less common forms of training are a program

preparing graduate students for early childhood development consultation (Stollak 1978) and a program that prepares counseling psychologists for filial and conjugal consultation (Guerney 1978).

Alternative Settings for Training

The first training for consultee-centered consultation spanned the boundaries of mental health professions; trainers and students from social work, psychiatry, psychology, and nursing participated in the postdoctoral program Caplan created at the Harvard School of Public Health in the 1950s (1970). Cooperative training efforts between these groups are less evident today; each profession typically trains its own students. The degree to which consultation training is available varies greatly within and between these professions.

Intradisciplinary Settings

Within the psychiatric profession, traditional training for the clinical or consultant-liaison model continues in hospitals and clinics under staff supervision (Eaton et al. 1977; Houpt et al. 1977; McKegney and Weiner 1976; Schubert and McKegney 1976). Within psychology, the specialty area of school psychology most often trains its students in consultation (Bergan 1977; Conoley 1981; Gallessich 1974; Lambert et al. 1975; Johnson 1977; McBride and Morrow 1977; Meyers et al. 1981; Tindall 1973). Interest in training counseling psychologists for consultation is growing (Cochran 1980; Gallessich 1980; Leonard 1979). Although consultation was conceived as a primary strategy in the community psychology movement, today only about half of the 29 programs listed in a recent issue of the American Psychological Association's Division of Community Psychology Newsletter include courses or experiences in consultation (Lorion 1981). Only five of these programs require a course in consultation. Consultation training in the clinical psychology specialty seldom appears in academic settings; however, students from these programs typically go to internships in hospital settings which require training in the clinical or psychiatric liaison model (Gallessich 1984; Tuma and Schwartz 1978). Consultation is offered to social workers (Kaslow 1977; Smith 1975), nurse practitioners (Thurman and Snowe 1976), and educational professionals (Cavalluzzo 1974; Jung 1977; Stapleton 1975). Consultation training is strongly recommended for counselor educators (Brown and Jackson 1976; Dinkmeyer and Carlson 1977; Gallessich and Ladogana 1978; Jurowicz 1982; Randolph 1974; Quinn 1977). According to one survey, about 95 percent of the counselor education programs include consultation, either through

a separate course or as a part of another course (Splete and Bernstein, 1981).

Interdisciplinary Settings

Professionals outside the mental health fields are increasingly participating in the training of mental health consultants (Long 1983). In academic institutions, departments such as management, rehabilitation counseling, labor and industrial relations, journalism, human development, education, and public affairs offer courses relevant to the consultant role and to the mental health of individuals and groups (Campbell 1978). Students from mental health professions, because they often cannot find adequate training in their own schools, enroll in these courses. Moreover, in some of these academic institutions, entire programs and departments are being created to prepare graduates for consultation (Campbell 1978; Gallessich 1982). Their interdisciplinary faculties often include mental health professionals, and the programs frequently have a strong mental health orientation. These programs are producing new types of professionals, individuals whose expertise includes mental health expertise as well as knowledge and skills in such fields as administration and organizational sciences.

To illustrate, the Harvard School of Education offers both master's and doctoral degrees in organization development and organizational behavior. The Graduate Center for Human Development of Fairleigh Dickinson University offers a master's degree in human development that includes consultation training as well as teacher education, group leadership, and human relations training. Case Western Reserve University has a master's program in organization development and analysis within the Department of Organizational Behavior. This program includes courses in several consultation models and a wide array of supportive courses such as community development, administration, health care management, general systems theory, and personal development. The University of Kansas offers master's and doctoral degrees in organization development, organizational behavior, community development, and consultation within the Department of Speech Communications and Human Relations. Advanced degrees in human resource development are offered in many universities; for instance, both master's and doctoral degrees in human resource development are offered in the College of Education at the University of Texas at Austin. A proposal to carry this trend further would establish a comprehensive 4-year Ph.D. program to educate and train consultants to work with human service agencies (Gallessich 1982). Such a program could be organized as a specialty in

an existing program or department and offered at the pre- or post-doctoral level.

Outside academic institutions, the trend toward multidisciplinary approaches to consultation training is even more pronounced. Nontraditional, interdisciplinary organizations offer workshops, seminars, publications, and supervision to individuals from many fields, including mental health professionals. Leading in this direction are the National Training Laboratories' Institute of Applied Behavioral Science, University Associates, the American Society for Training and Development, and the Organization Development Network. Besides basic consultation theory and process, the topics of workshops and institutes offered by these institutions include stress management, ecology of work, human resource and organization development, and management of change in complex systems.

Training Patterns: Questions and Answers

Evolving from modest and informal beginnings, consultation training today is offered in many settings. It takes many forms and serves diverse goals. It has been directly shaped by developments in consultation practice and particularly by the dominant models described earlier. Rather than leading to revisions in existing training, each new consultation model has led to the creation of new training paradigms especially tailored to produce a distinctive set of competencies. New consultative practices continue to appear; additional dominant models will surely develop. But the lines separating consultation models are softening. The commonly accepted model designations, which never fully described or differentiated all practices, are less adequate than ever to define the field. Practitioners often combine parts of two or more models. For instance, in working with a school principal on a behavioral program to improve students' behavior in the cafeteria, a consultant follows a behavioral consultation model most of the time; however, this consultant shifts into the more subtle mental health model whenever the consultee talks about his reactions to several particularly troublesome students and asks the consultant's help in understanding and working with these youngsters. The emergence of new, specialized consultation focuses--such as human resources management, health education and promotion, and job relocation problems--increases the difficulty in classifying a consultant's role and functions within a single model.

With the blurring of lines differentiating models, trainers have more latitude than ever before in designing programs. They may continue to train students to work in established models or attempt to prepare them to serve in less well-charted roles.

Decisionmaking has become a complicated affair. The following pages discuss the crucial questions trainers must consider and the various ways they are answering these questions.

What Will Be the Goals?

Answers to this question vary greatly. The overriding decisions are (1) the particular model or practices for which trainees are to be prepared and (2) the degree of comprehensiveness of the training. The goals of most programs are closely tied to the dominant models described earlier. Most academically based programs attempt to prepare trainees with all the competencies needed for one particular model, for instance, a behavior approach (Bergan 1977; Bergan and Schnaps 1983; Dorr 1978), a consultee-centered approach (Lambert 1983), or an organizational approach (Keys 1983). Some programs, however, prepared graduates with all or most competencies needed to practice in several consultation models. Particularly common are programs that combine preparation for consultee-centered and organizational consultation. But most current training opportunities are found outside academia in brief workshops with very limited goals. For instance, the goal may be to develop competencies for a specialized area within a consultation model; to illustrate, workshops offered by the National Training Laboratories (NTL) and University Associates often focus on such circumscribed topics as consulting with organizations contemplating mergers or consulting with organizations experiencing decline. The goal may be to equip trainees with knowledge or skills useful in any consultation approach.

Training programs in both traditional and nontraditional educational settings reveal a trend toward differentiation of generic goals--competencies needed in most or all consulting--from specialized goals--competencies needed only for particular types of consulting (Gallessich 1982). Generic competencies include knowledge and skills in such areas as organizational diagnosis, entering organizations, and contracting. Knowledge and skills in research and evaluation are also recommended as part of the generic repertoire (Broskowski 1978; Gallessich 1983b; Keys 1983; Mannino and Shore 1980, 1983).

Who Is To Be Trained?

Training is usually available only to individuals who are preparing for or practicing at the entry level of their professions. For psychiatrists and psychologists, the entry level is the M.D. or Ph.D.; in fields such as social work and counselor education, the master's degree is the entry level. Paraprofessionals were trained

in consultation during the early years of the community mental health movement (Cowen et al. 1973; Nyman et al. 1973; Suinn 1974). But these programs, characterized by narrow objectives, were more technical than professional in emphasis. Some evidence of training of paraprofessionals is still found; for example, staff members in a university counseling center prepare undergraduates to consult with campus student organizations (Presser et al. 1984). Suggestions for training consultees have been offered (Bardon 1977), but little evidence of efforts in this direction has appeared.

At What Point in the Career Span Should Training Occur?

The first consultation training took place at the internship, residency, or postdoctoral level (Caplan 1970). This pattern continues, but, in addition, training is now offered at all career stages. In academic settings, consultation training is most often placed in the last year—following more traditional coursework and practicums. Some trainers, however, prefer that consultation training parallel or precede training in basic services; they hope through this arrangement to insure that consulting skills are integrated into the professional repertoire (Hartsough 1972; Lambert et al. 1975). Midcareer training is offered through inservice and continuing education programs in clinics, counseling centers, schools, hospitals, and welfare departments (Aiken 1974; Broskowski et al. 1973; Gallessich and Ladogana 1978; Jacobson et al. 1983; Signell and Scott 1972; Walsh 1973).

How Long Should the Training Program Be?

The relatively comprehensive goals of most university consultation courses require a calendar year or an academic year. (At the other extreme, Sutherland in 1968 proposed an 8- to 10-year program to prepare consultant-therapists to work in comprehensive psychiatric service centers in England. Personal analysis and long-term supervision are emphasized in this program.) Consultation training institutes, typically intensive in nature, usually are 2 to 4 weeks in length (Campbell 1978). Shorter programs, such as the 1- and 2-day workshops offered by educational and professional organizations, are geared for limited goals such as providing an introduction to consulting or filling in gaps in consultants' backgrounds.

Should Clinical Expertise Be a Prerequisite?

Trainers disagree on this issue. Some trainers insist on prerequisite clinical training for clinical, consultee-centered, and organizational consultation (Altrocchi 1972; Caplan 1964; Goodstein 1978; Levinson 1972). Bindman (1966), for instance, contends that experience as a psychotherapist is essential to understanding the intrapsychic and interpersonal processes (including the unconscious dynamics) inherent in consultative work. He also advises trainees to obtain a thorough background in personality theory and appraisal. The premise is that successful consultation requires the clinician's sensitivity to subtle nuances of style, defensiveness, transference, and countertransference. But some trainers argue that the clinician's biases toward pathological interpretations of behavior and toward individual levels of analysis interfere with the consultant's functioning (McClung and Stunden 1972; Parker 1961, 1968). Their rationale is that whenever individuals try new roles they feel insecure and consequently are likely to revert to well-learned behaviors; clinicians attempting to practice consultation are likely to frame problems in a pathological framework and react to them accordingly.

This question remains controversial; but since the training programs of most mental health professions require at least a modicum of clinical expertise, consultants from these fields are likely to acquire clinical skills prior to or along with consultation skills.

What Bodies of Knowledge and Skills Should Be Included in the Curriculum?

In brief programs with narrow goals the answer to this question varies greatly. In the more comprehensive programs, similar core topics appear. Theories of organizations and clients are commonly taught. Most trainers include theories of social systems and group processes, along with methods for diagnosing and intervening in these levels. Individual behavior and assessment is included in most programs preparing students to work in clinical, behavioral, and consultee-centered models. In addition, consultation theory is a major element in most curriculums and is followed with training in a broad array of principles and skills such as those related to entry, contracting, ethics, diagnosis, intervention, evaluation, and termination. Self-understanding is emphasized in many programs by trainers who seek to increase students' awareness of their unique characteristics and their impact on consulting. Skill in interdisciplinary team work is a part of some training programs.

In general, consultation training programs appear to be moving toward a greater emphasis on theoretical foundations, on the integration of theory and practice, and toward interdisciplinary content.

What Methods Will Achieve the Training Goals?

Consultation training methods, originally informal and simple, are increasingly formalized and varied. Programs with comprehensive goals usually use academic or didactic approaches along with laboratory, field placement, and supervisory methods (Conoley 1981; Gallessich 1974, 1982, 1983b; Hartsough 1972; Kurpius and Brubaker 1976; Leonard 1979; Weinstein 1981). Goals of brief programs such as workshops or institutes typically require only lectures or laboratory training.

Academic methods such as lectures, discussions, and reading assignments are used by most trainers to teach the knowledge bases needed for consultation (Alpert et al. 1980; Bergan et al. 1980; Conoley 1981; Dorr 1978; Froehle 1978; Gallessich 1974, 1982, 1983b; Guernsey 1978; Hartsough 1972; Kuehnel and Kuehnel 1983; Kurpius and Brubaker 1976; Lambert 1983; Leonard 1979; Lippitt and Lippitt 1978; Lynch and Lombardi 1976; Randolph 1974; Stum 1982; Weinstein 1981). Among the most frequently cited texts for consultation courses are The Theory and Practice of Mental Health Consultation (Caplan 1970) and Process Consultation (Schein 1969). Comprehensive descriptions of academic assignments are available. They usually include written papers such as entry reports, logs, comparisons of various consultation models, analyses of the functioning of client organizations, and evaluations of the consultation service.

Laboratory methods are frequently included in consultation training (Conoley 1981; Gallessich 1974, 1982; Kuehnel and Kuehnel 1983). Modeling, videotaping, and group process exercises are commonly part of laboratory training. Role-play is popular and is often videotaped so that trainees can see themselves in action and give each other feedback. Fish-bowling is another frequently used laboratory device; in it trainees form two concentric circles and the outer group observes the inner group's processes in accomplishing an assigned task (such as making a decision or building a block tower). The goals are to enhance trainees' process consultation skills and to provide individual feedback on consultation style. The use of trainer modeling has been recommended (Kuehnel and Kuehnel 1983; Kurpius and Brubaker 1976; Leonard 1979; Lynch and Lombardi 1976). In one program trainees watch and listen to video and audiotapes of their instructor and other consultants as they consult with various populations (Randolph 1980).

Subsequently, students tape simulated consultation interviews and receive feedback on them. Trainers also design special laboratory exercises to focus on such organizational and consulting issues as trust, power, race, and gender (Leonard 1979).

Field experiences are emphasized by most trainers. Programs vary widely in the numbers and types of settings available to trainees. The placements may be brief--two or three visits--or they may last a year or more. The trainee role varies; it may be apprentice, co-consultant, solo practitioner, or member of a consultant team. Most trainers recommend careful selection of sites. Stressing trainees' need to experience some modicum of success, Leonard (1979) outlines the environmental and political conditions that sites should provide. Kuehnel and Kuehnel (1983) suggest careful grading of the field experiences. They recommend that trainees first consult in a client- or consultee-centered model prior to focusing on larger units. If a trainee experiences problems gaining entry, they recommend a change of sites; their rationale is that a series of short-term successes is preferable to one long, unsuccessful consultation. Opportunities for depth and breadth of experience are also considered to be important criteria in site selection (Conoley 1981). Some trainers consider it imperative that students be integrated into an already established consultation service if they are to have a successful experience. Conversely, some trainers recommend that students assume full responsibility for selecting sites and initiating consulting relationships (Lynch and Lombardi 1976).

Supervision of field placements involves some of the most difficult trainer decisions. Trainers frequently comment on the stressful nature of early consultation experiences (Berken and Eisdorfer 1970; Gallessich 1974; McClung and Stunden 1972). The entry period is especially difficult. Trainees in preservice programs are especially anxious because of their need to attain professional credibility; however, midcareer trainees who have already achieved professional status may find the student role disconcerting (Signell and Scott 1972). Moreover, the marginality of the consultant role thwarts trainees' affiliation needs. Trainees are also bewildered by the volume and complexity of information that confronts them and by the number of options as to goals, points of intervention, and consultant roles. They may feel compelled to find and give the "answers" to consultees' problems (Hollister and Miller 1977), yet trainers caution them to delay intervention in order to gather more diagnostic information. Trainees' inner pressures for decisive assessments and actions are reinforced by organizational pressures for immediate solutions. Tensions arise from other sources. The nature of the role allows little clear feedback and recognition. Changes are often intangible; moreover, credit for solutions is likely to go to consultees.

Discrepancies between agency values and trainees' values often appear. Lack of control over outcomes can be disheartening. Trainees are disappointed when, because of consultees' lack of skill or motivation or because of agency constraints, planned changes do not occur. The consultant-trainee may feel overwhelmed by the flaws they see in consultees (Levinson 1978). They may also resent the supervisor's control.

The role of consultation supervisor is inherently problematic (Conoley 1981). Trainers must model good consulting skills in order to foster student learning; at the same time, they must fulfill the demands of the supervisory role. Keys (1983) believes that at the heart of the supervisor-supervisee relationship is the dilemma of freedom versus constraint (Keys 1983). How much freedom should students have in regard to courses, field placements, and research? How much supervision is needed to enable students to learn how to function independently? Key's answer is to begin with a relatively high degree of constraint and move progressively toward greater and greater freedom.

Trainers' approaches to supervision vary greatly. Many prefer the apprenticeship model (Altrocchi 1972; Backer 1982; Leonard 1979; McGreevy 1978; Whittington 1968). However, group supervision is most often described in the literature (Caplan 1970; Cohen 1976; Conoley 1981; Gallessich 1974, 1982; Weinstein 1981), although at least one trainer believes that group supervision is inadequate for responding to individual needs (Hartsough 1972). Trainers note that group supervision increases opportunities for role modeling and peer feedback. It also provides trainees with experiences in critiquing group members' work. Groups provide opportunities to learn about the operations of a variety of organizations and to observe different consulting styles. In group supervision, trainers sometimes focus on group processes. In one approach, group themes and emotions are identified and interpreted; the rationale is that these themes and emotions are analogous to salient events in group members' lives, particularly in regard to their professional role development and to their experiences in their field settings (Gallessich and MacDonald 1981).

Weinstein (1981) noted three major themes arising in trainees' role-definition problems, level-of-analysis problems, and implementation problems. Role-definition problems stem from the marginality of the consultant role and from students' feelings about inexpert status. Level-of-analysis problems arise when trainees struggle to organize and interpret the data related to their consultees' concerns. Can the "problem" be best framed from an individual, role, group, or systems perspective or through some combination of these? Implementation problems develop from trainees' inability to get limits; for instance, they may

accept requests for which they lack time and expertise for adequate service.

Three dimensions along which supervisory models differ--structure, function, and format--have been identified (Alpert et al. 1983). The structure of supervision is related to the supervisor's base and the placement site, both of which may be either university- or field-based. The function of supervision may be either pedagogical or therapeutic and the format of supervision may be individual or group. Since these dimensions are conceived as continuous rather than dichotomous, there are potentially many different models of supervision. These authors describe a vertical supervision model used at New York University to train predoctoral school psychology students for school consultation. There are three supervisory levels in this model: student supervisors, advanced student supervisors, and professional supervisors. Each level in the hierarchy is supervised by the level just above it. The authors contend that this model reduces trainees' anxiety since they are more comfortable discussing concerns with student supervisors. Trainees also benefit from input from multiple sources and the more intensive and frequent supervision that this less costly approach makes possible. Student supervisors gain supervisory skills and faculty members gain time for other activities. However, multiple input sometimes confuses and overwhelms trainees. In addition, trainees sometimes do not accept the input of their student supervisors. Another disadvantage is that student supervisors may require so much time from faculty supervisors that the timesaving potential of this arrangement is lost.

What Innovative Methods Are Appearing?

Trainers report a number of fresh, creative approaches. In one program trainers increase students' responsibility by requiring them to create their own curriculum (Lynch and Lombardi 1976). The first class meeting is devoted to identifying student goals and collaboratively constructing a course outline to reach these goals. In one of these classes, the topic sequence that emerged began with defining the roles of consultant and consultee; it expanded into discussions of processes, types, models, and evaluation. Issues related to ethical and legal aspects of consulting, political implications, and the emerging social role of the consultant were the topics of the final weeks of the semester. Based on these student-inspired topics, the instructors developed reference lists for each topic. Each student developed an individual contract that specified required academic and experiential work.

A unique self-supervision method is suggested by Guernsey (1978). Students videotape their consultation sessions and watch

them shortly thereafter. They are instructed to supervise themselves as if they were providing feedback to a peer. They take notes on appropriate and inappropriate behaviors and outline suggestions for improvement. Another unusual training feature, found in the school psychology program at the University of California at Berkeley, is the opportunity for consultation trainees to experience being a consultee as well as a consultant (Lambert 1983). Trainees meet weekly with their consultant, a child psychiatrist, to discuss problems in their early experiences as consultants.

Some trainers recommend use of competency-based education and training (Jennings 1983). In the model suggested by Froehle (1978), students are told what competencies are required and the operationally defined criteria for evaluation of their performances. Thus, criterion-referenced objectives are the heart of competency-based education (CBE). Froehle considers three types of competencies to be necessary for the consultant: knowledge, behavioral skill, and judgment. He suggests designing individualized learning programs so that students can develop mastery of each area as needed.

A more detailed model for competency-based training in behavioral consultation is presented by Began, Kratochwill, and Luiten (1980), who recommend establishing three sets of objectives: (1) specific training objectives related to verbal knowledge, skilled behavior, and expected outcomes; (2) training procedures that lead to mastery of both verbal knowledge and behavioral skills objectives, and (3) evaluation procedures for these objectives. These authors include evaluation checklists which specify the types of verbalizations that are expected to occur in interviews. An observer checks off each verbalization type as it occurs and later tallies them to get a frequency measure. Another evaluation method is the consultation analysis record. This form allows the observer to classify all verbalizations in the interview so that patterns may be identified. If a particular interview, for instance, requires discussion of three specific areas, the consultation analysis allows objective measurement and evaluation of how well this requirement was met. Both forms of behavior skills evaluation as well as verbal knowledge evaluation provide feedback to the instructor and students as to specific needs for additional training.

Another innovative approach involves rapid training (Dorr 1978; Stum 1982). Stum claims his method, DIRECT, takes a total training time of 4 hours. During this time trainees read an explanation of the DIRECT model, observe the author in a DIRECT consulting session, and discuss the model's goals and use. Two more hours are spent in actual practice and critiquing. Stum

contends that through these 4 hours of training counselors attain identifiable and measurable skills in consulting. He suggests this model can be used in conjunction with other training approaches.

Some trainers recommend self-guiding packages (Cochran 1980; Leonard 1979). Leonard points out that because of the enormous amount of coursework required by most doctoral training programs, it is not feasible to require courses in all the areas in which consultants should become competent. As a remedy for this problem, she suggests the creation of learning packets of specific skills-training modules.

What Developmental Processes Are Involved?

The developmental nature of consultation training has been noted and suggestions for facilitating trainees' movement through predictable stages have been proposed. One trainer outlines four stages of training and describes the role of the supervisor in each stage (Cohen 1976). The first stage is "unilateral dependence"; trainees at this point are searching for the "right" answer and the supervisor takes the role of co-consultant. "Negative independence" is the second stage. It comes with solo movement into a field placement and is marked by cognitive rebellion. The supervisor's task in this phase is to provide alternative views from which trainees can choose; the supervisor also ensures that trainees receive adequate peer support. In the third stage, "dependence and mutuality," trainees experience empathy and commitment to each other; the supervisor's leadership becomes less important. The fourth and final stage is "independence." At this point trainees are comfortable with their competencies and ready to practice independently; the supervisor's task is to assist trainees in working through the termination process.

Trainees' crises paralleling events in the progression from entry to termination are described by Signell and Scott (1972). The first stage is role shock; next come the stages of trial and error, regression and consolidation, and termination. Roney and Gallessich (1980) noted a predictable sequence of trainee concerns in an analysis of group supervisory sessions over an 8-month period. In the early weeks trainees were most concerned with external matters, particularly with their role as consultants, consultees' behaviors, and organizational phenomena. By midyear, trainees' focus shifted to intrapersonal concerns and relationships with consultees. By the end of the training, an integration of external and internal concerns appeared. These authors conclude that trainers need to provide a different type of support for each stage.

Recognizing these developmental needs, Jacobson, Ravlin, and Cooper (1983) outline a design for a continuing education program in which the activities are arranged to parallel trainees' sequential needs. The trainees, staff members of a mental health center, begin with coursework in which they study the relevant consultation literature. They also peruse the center's archives to obtain a historical sense of consultation offered by the center. Trainees then progress through a graduated series of field placements; they begin as observers, move into junior apprenticeship roles, and advance to the status of full member of consultation teams. Solo consulting experiences then begin with restricted, time-limited contracts and later move to more comprehensive commitments. Next, each trainee contracts for an extensive consultation with one organization; this relationship spans several years and focuses on many aspects of the client organization. Finally, trainees are expected to consult with a variety of client systems.

How Will the Training Program Be Evaluated?

On the whole, published descriptions of consultation training programs suggest that little is done to objectively and systematically evaluate outcomes. The evaluations that have been reported suggest that training positively affects the consultant, the client, and the consultee (Trickett and Grady 1983). Consultants report more professional self-confidence after training; consultees report increased insight and changes in their clients' behavior. However, little has been done to identify the variables that account for these changes, and trainers have expressed much concern over the gap between training and evaluation research (Bergan 1977; Broskowski 1978; Dorr 1978; Gallessich 1983b; Goodwin et al. 1971; Medway 1982; Meyers et al. 1979).

The most common approach to evaluation is through trainees' self-reports obtained at the end of the training period. For example, Lynch and Lombardi (1976) evaluated their training program by asking trainees to respond to open-ended questions that assess the overall value of the course and of the instructors' effectiveness. Students reported discomfort with aspects of the training that required initiative and risk taking. Another approach to evaluation employed ongoing self-report measures (Broskowski et al. 1973). In this continuing education program, trainees met a half-day a week for 12 weeks; each session began with a general lecture followed by small group discussions. After each lecture, trainees rated the speaker and reading assignments in terms of their job-related usefulness and communication value. After the group meeting, they also rated the group process along eight dimensions: participation, leadership, comfort level, topic focus,

influence and change, new ideas and skills, problem solving, and planning and change. Anonymous written comments were also elicited. Weekly evaluations were regularly discussed and considered in ongoing modifications. A final comprehensive questionnaire was used to assess trainees' ratings of the seminar's design and operation. Eighty percent of the respondents (25 out of the 40 trainees responded) reported positive changes in such areas as work behavior, attitudes, expectations, and self-confidence. Walsh (1973), in a posttraining evaluation, found that trainees found sessions on consultation theory to be most helpful and exercises focusing on interpersonal styles to be least helpful. Jennings (1983) reported results of a followup survey of individuals trained in a 9-month consultation training program at the University of Texas over a 10-year period. These individuals recommended broadening and lengthening the course and increasing the use of concrete feed-back, role-play, and videotaping. They found the field placement and small-group supervision to be the most helpful aspects of their training.

Some training programs are evaluated by measures of actual performance during the training period. An indirect measure of trainees' success in consulting was reported in a psychiatric residency setting (Schwab et al. 1966). The number of early requests (defined as within 48 hours of admission) for consultation increased significantly following the institution of the consultation training program; moreover, the overall number of requests increased from 255 to 425 within 2 years after the program began. Other trainers obtain direct evaluations of trainees' performance during the training period from consultees or field supervisors (Conoley 1981; Gallessich 1982); generally, these evaluations indicate high levels of satisfaction with trainees' work. Some trainers, particularly those preparing consultants for behavioral approaches, design training procedures based on specific measurable objectives, including field-site performance (Bergan et al. 1980; Froehle 1978).

Several trainers have reported outcome evaluations. Randolph (1980) asked employers to rate the performance of 30 master's-level students whom he had trained in consultation; the mean rating for job performance was 4.55 on a 5-point Likert scale in which 5 was the highest possible rating. Goodwin and Coates (1974) assessed the effectiveness of a school psychology consultation training program by assessing consultant, consultee, and client change. Significant gains in consultants' knowledge and behaviors and in teachers' behaviors were found, along with dramatic changes in the behavior of the clients (schoolchildren). Gallessich and Ladogana (1978) reported the results of a four-pronged evaluation of an inservice consultation training program for school counselors. Using a pre-post design, they found that principals, teachers, and students perceived significant increase in the degree

to which counselor-consultants collaborated with members of their faculty and staff. The trainees reported similar positive changes in their relationships with faculty and staff. In addition, trainees' evaluations of the program design were highly positive.

Future Directions

Consultation training has been institutionalized by the mental health professions. It is now available at multiple career points and for diverse purposes. However, information regarding training outcomes is very limited. Moreover, there is a serious lack of knowledge about the varied consultation practices in which trainees are engaged; consultants' roles and functions and the competencies needed for effective consultation are not well understood. A much more reliable data base than currently exists is needed to design training programs and to evaluate their effectiveness. Outlined below are the recommendations for future directions:

For the Long-Term: Basic Research

A more concerted and continuing effort is needed to gather valid data about the practice of consultation (Gallessich 1983a). Feedback loops from multiple perspectives--perceptions and observations of graduates, senior consultants, clients, and researchers outside the consultation field--are needed. Input from members of other disciplines--from such fields as management, communications, and physical health professions--who face similar problems and issues is needed. This effort will require a variety of methods including interviews, surveys, and both structured and unstructured observations.

Interim Guidelines

While awaiting answers to the questions outlined above, trainers must use existing knowledge, piecemeal though it is, to make judgments regarding training. Interim directions should include the following:

Increased professionalization. As a specialty, consultation is maturing. Training goals, curriculums, and methods should be more carefully and precisely chosen, planned, and implemented. Trainers should seek to inculcate more explicit and rigorous standards of practice and ethics and a more scientific orientation to consulting.

Interdisciplinary curriculums and settings. Trainers should continue to extend the consultation knowledge base beyond professional boundaries and to experiment with interdisciplinary approaches to facilitate the assembling and integrating of the bodies of knowledge needed by consultants of the future. For instance, collaboration with educator-trainers from sociology, management, communications, computer science, and program evaluation should be considered.

Systems approaches. A systems approach is needed to construct and evaluate training models. Colleagues from program evaluation can assist in applying systems' principles and theory to the design of training modules and programs with specified parameters that facilitate analysis and evaluation (Borich and Jemelka 1982). Training models--whether brief or long-term--can best be conceptualized as systems composed of subsystems. The range and limits of objectives and inputs should be specified. For instance, the characteristics and prerequisites of entering students should be explicated. Program constraints, formal operations, elements within operations, and linkages between them should be specified. Feedback loops should be created for each programmatic component as well as for the entire system.

Evaluation can be conceptualized in three stages. The first calls for evaluation of the degree to which trainees achieve the competencies their programs are designed to produce. Stage two evaluates trainees' abilities to apply these competencies in actual field practice. Stage three calls for the creation of varied training models that seek the same objectives; thus comparisons can be made of the success of graduates of alternative models in reaching the same goals (Gallessich and Ladogana 1978).

Diverse programs and packages. Continuing experimentation with varied programs and packages that respond to wide-ranging organizational and trainee interests is needed. Training programs should include diverse goals, periods of time, settings, curriculums, methods, and designs. Among the more lengthy programs should be some that are general in nature and which emphasize indepth education and training in organizational behavior, consultation theory and process, and research and evaluation. Some should emphasize specialized forms of consultation for particular types of organizations and problems. Some should prepare consultation research specialists, individuals who can strengthen the scientific bases of consulting. Universities should continue to offer education and training at the pre- and post-doctoral and continuing education levels. But much of the leading edge of training will continue to come from outside universities in programs sponsored by various professional and educational organizations. Curriculums should include the generic topics referred to earlier, such as

organizational behavior; consultation theory, principles, and processes; and understanding of self in the consultant role. Training in many specialized approaches should be offered. Specialists in familiar areas such as organizational diagnosis, management coaching, team development, conflict negotiation, process consultation, evaluation, and stress management are needed. Emerging specialty needs include competencies for working with employee assistance programs, human resource development, and computerization of communications and operations.

Systematic experimentation with and evaluation of the outcomes of a wide range of methods and packages are needed to ascertain the unique advantages and limits of each of the commonly used methods--academic, laboratory, field placements, and supervision. Trainers should consider the use of various forms of supervision. Comparisons of outcomes of the apprentice model and other supervisory approaches should be made. Trainers need to explore newer methods such as computerized learning packages and peer study groups to extend the capabilities of training programs.

Development of diagnostic instruments. Trainees' needs vary greatly. Diagnostic tools could enable trainers to determine individual needs and could be used in conjunction with all programs, including those for practicing consultants, individuals who seek midcareer respecialization, and those in predoctoral programs. The development of diagnostic instruments would enable trainers and trainees to design individualized training programs to meet unique needs. Many individuals, for instance, might need only programmed readings or videotaped packages to accomplish certain goals.

Organizing and collaborating by consultants and consultant-trainers. Good programs can no longer be produced by individuals. Trainers need to draw together the people concerned with consultation practice and training issues and create intradisciplinary and interdisciplinary councils to pool data and solve problems. Some important movements in this direction have appeared (Alpert and Meyers 1983). More intensive efforts are needed.

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CHAPTER 12

THE ORGANIZATION AND DELIVERY OF MENTAL HEALTH CONSULTATION IN CHANGING TIMES

Beryce W. MacLennan, Ph.D.

Introduction

Consultation refers both to the special technology of consultation focused on assisting responsible individuals or groups to identify and solve specific problems, and also to the hiring of outsiders to perform a wide range of tasks which may or may not include the use of consultation as a method. These tasks may also include conducting surveys, program evaluations, staff development training, method demonstrations, or records review. This chapter is primarily concerned with the organization and delivery of consultation services in the first sense. However, modern consultation often combines a variety of functions with the consultant occupying several different roles. Thus, consultants may perform a mixture of technical assistance tasks.

This chapter will briefly examine the changing nature of society and its effects on the delivery of mental health consultation over the last 50 years. Some of the differences, which affect consultants and how they have had to shift priorities, change their goals, and rearrange the organization of their work, will be described. The impact of these changes on the delivery of community mental health center consultation will be discussed. Community mental health consultation uses the same methods and techniques, but is viewed as different and is treated separately for the following reasons: Community mental health consultation is designed to improve the mental health of the residents of a particular geographic area, whether one or two census tracts, a city, or a State. It is conducted out of an organization, State, county, city, or local, public or private, which has the improved mental health of area residents as the primary goal. Consultation to a particular consultee is selected from a range of direct and indirect service interventions, based on needs assessment and strategic planning; and the consultation is coordinated with other community mental health and human service interventions. The ideal is a well-conceived consultation program, not a number of individual disconnected consultation arrangements.

Although some aspects of the organization of mental health consultation remain constant, many activities will depend on the

nature of the setting and the overall goals and priorities of the individual or agency offering consultation. Consultation is offered out of three major types of settings: (1) community mental health government agencies and centers, (2) independent consulting firms and private consultants, and (3) in-house expert consultants employed by human service agencies or businesses. Each of these settings has its disadvantages and advantages. The motives, status, and problems encountered vary considerably between settings. However, the process of consultation and the technical aspects of negotiating the initial contract, maintaining records, billing clients where appropriate, and assessing the effectiveness of consultation will not vary greatly.

Past Trends in the Delivery of Mental Health Consultation

The amount of mental health consultation being carried out in the United States has grown extensively over the last 50 years. However, community mental health consultation, as a component in a carefully coordinated system of care, appears to be on the decline in the early 1980s.

The Early Years

Most early mental health consultation was offered by psychiatrists to mental hygiene clinics, family agencies, or hospitals, although some consultation was provided to schools and to welfare agencies, sometimes by experts in other mental health disciplines (Mendell and Solomon 1968; Mannino and Shore 1969). Consultation was focused on assisting staff, usually other mental health professionals or physicians, to understand and manage the psychological problems of their patients or clients. Essentially the consultant's role was limited to enhancing the quality of the consultee's performance. Consultants were either members of the staff of the organization, such as in hospitals, or they were hired by the agency on personal service contracts. Funding was provided by the organization out of charitable or public funds. Some papers were written reporting these activities, but there was little systematic theory. Few mental health professionals had experience or training in consultation.

The Rise of Community Mental Health Centers

In the 1950s, stimulated by demonstration funding from the National Institute of Mental Health (NIMH) and community

mental health legislation in some States, more broadly based consultation began to be offered to a variety of human service providers and Caplan developed his famous categorization of consultation types (Caplan 1959, 1970).

A major impetus toward the development of mental health consultation came with the funding of consultation and education as one of the five essential services required to obtain staffing grants under the Community Mental Health Centers Staffing Act of 1965. Through their efforts to bring service providers together to extend existing mental health services and to deliver new programs through consultation to the human service administrators, and through consultee-centered and case consultation, the community mental health consultants resolved and prevented mental health problems and enhanced the quality of mental health in their geographic areas. They became service providers in their own right, extending the reach of the mental health center into the community. They were also seen as a solution to the shortage of mental health professionals, a critical problem at that time.

Yet even with the support of Federal funds, consultation was slow to develop. Many mental health professionals were not trained in consultation and did not understand the ideas behind community mental health consultation nor how to deliver this service. Initially, most consultation was ad hoc and focused on case management. A very few centers such as the Range Community Mental Health Center in northern Minnesota (Hunter and Ratcliffe 1968) and the NIMH intramural demonstration at the Mental Health Study Center (MacLennan et al. 1970) developed consultation as a primary service which helped other human service providers to manage day-to-day problems; to develop specialized, needed services and training; and to identify and refer those requiring specialized mental health treatment to the direct service programs. A small number of other centers such as the Center at San Mateo (Calif.) organized separate consultation services (Lamb et al. 1969). However, most centers merely undertook a small amount of case consultation, often related to some staff person's special interest.

In 1968, in visits to 10 community mental health centers known to have the most active consultation programs at that time, MacLennan identified three patterns of consultation: (1) community liaison, including systems consultation to other human service providers, as a central service of the center; (2) consultation organized out of an independent department, often but not always undertaken by staff who were not also providing direct services; and (3) consultation provided by clinicians in the course of their direct service work.

Debate was centered on the extent to which consultation and education (C&E) should be integrated with other services, the extent to which different types of consultation should be represented, and by whom it should be delivered. Early guidance from NIMH was primarily concerned with the definition and scope of consultation. However, by 1970 concern was being expressed regarding the extent to which the centers were organized to provide consultation as a discreet service with staff who would be responsible for the program. Both Public Law 94-63 enacted in 1975 and the Mental Health Systems Act of 1980 required a full-time program director.

The Joint Commission on the Accreditation of Hospitals (1979), the National Institute of Mental Health (1971), and the National Council of Community Mental Health Centers' Council on Prevention (Snow and Swift 1981) all developed standards relating to the organization and administration of C&E—the last of these being the most comprehensive. Snow and Swift (1981), in recommending policies and procedures for C&E services, stated that there should be an identifiable administrative unit for planning and implementing services to develop, coordinate, integrate, and supervise all C&E. The person given this responsibility should be included in the center's executive management.

Perlmutter and Vadya were also interested in the organization of consultation and in 1979 defined the advantages of centralized versus decentralized consultation programs. They stated that centralized programs are more visible, cohesive, and more likely to be better planned. They possess greater program autonomy and are likely to pay more attention to overall catchment area needs. In addition, in centralized programs, there is likely to be more commitment to the program. On the other hand, the integration of consultation with the clinical program capitalizes on the clinical skills of the staff and permits for close integration of the consultation and direct services in satisfying the needs of other service providers. Structured units are more likely to have full-time C&E directors. Perlmutter and Vadya (1979) studied the relationship between the structure of C&E and the status of the C&E director at 33 community mental health centers (see table 1).

Table 1

Relationship of C&E Structure and the
Appointment of C&E Directors

| Structure of C&E | Full-Time | Part-Time | Total |
|------------------|-----------|-----------|-------|
| Structured unit | 16 | 2 | 18 |
| Decentralized | 8 | 7 | 15 |
| Unstructured | 0 | 0 | 0 |
| Total | 24 | 9 | 23 |

In order to assist in the development of consultation, NIMH published a reference guide to the literature (Mannino 1969) followed by a volume on the scope of mental health consultation (MacLennan et al. 1971). Also, types of consultation were defined more exactly for CMHC grant applications. To stimulate consultation and education, special grants were legislated under Public Law 91-211 in 1970 and in 1975, Public Law 94-63 allowed special consultation grants to continue after Federal support for a center was terminated. Interest continued to grow in the community mental health centers with Federal support, and staff competence also increased, with the development of a number of training efforts in the late sixties and early seventies until 1974, when, with 400 centers reporting, the maximum number of consultation hours were accrued (238,644) (see table 2). Subsequently, there was a steady decline in community mental health consultation until 1978. In 1979, 179,325 hours were reported in the annual inventory by 600 centers. For most of the years, the percentage of consultation hours to total hours averaged between 5 percent and 6 percent. Most experts believe that the decline in consultation activity has continued in the eighties (Stockdill 1982; Larsen and Jerrell 1984; Backer et al. 1983).

Early community mental health consultation was also divided over the issue of clinical versus community action consultation. Centers serving minority and poverty areas were concerned about the empowerment of the people and the reduction of learned helplessness (Perlmutter 1979). A few centers such as Lincoln Hospital Community Health Center in the Bronx trained members of the community in community organization. A center in Albuquerque, N. Mex., training Spanish-speaking residents as consultants to local agencies and citizen groups. The Mental Health Study Center in Prince George's County (Md.) provided consultation on community relations including school desegregation (Bradshaw et al. 1972). These issues are translated in the eighties into primary prevention concerns (Signell 1983) and consultation to mutual support groups (Silverman 1978).

Table 2. Hours of consultation by type of consultation
at community mental health centers, 1973-1979

| Year | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 |
|-------------------------|---------|---------|---------|---------|---------|---------|---------|
| No. of centers | 325 | 400 | 434 | 528 | 548 | 563 | 600 |
| Total con- sultation | 177,879 | 238,644 | 231,850 | 223,649 | 203,605 | 161,528 | 179,325 |
| Case | 83,598 | 105,072 | 108,499 | 101,984 | 90,970 | 64,695 | 87,231 |
| Staff & CE | 39,620 | 61,294 | 50,356 | 50,019 | 46,510 | 39,204 | 40,261 |
| Program | 54,661 | 72,278 | 72,995 | 71,640 | 66,125 | 57,629 | 51,883 |

Source: Bass 1974, 1982; NIMH Statistical Note No. 108, 1974.

The Decline of Community Mental Health Consultation

During the late sixties and early seventies there was not only enthusiasm for the community mental health center model and increasing Federal funding, but funds were also relatively plentiful enabling other human service providers to buy consultation services. However, as poverty program initiatives declined and as more centers matured and had to look beyond the Federal Government for funding, increased emphasis was placed by many centers on obtaining income from direct services reimbursable by insurance and Medicaid third-party payments. Direct service delivery and consultation to other primary providers for the purpose of assisting them to manage mental health problems without the need for specialized treatment have always been in competition, although the best programs conceived them as working in tandem. As centers had to become more self-sustaining and as funding for contracts from other public agencies dried up so that centers could only afford to offer limited consultation, revenue from direct services became increasingly attractive and necessary.

Woy et al. (1981) identified a dichotomization within community mental health centers in the late seventies and early eighties, with some centers concentrating on direct reimbursable services and other centers attempting to stay within the CMHC model. These latter centers attempted to obtain grants and contracts from their States, from other human service providers, and from industry. These programs are said to have serviced more low income, high-risk populations and provided more consultation to other service systems such as the schools, the health care system, and the criminal justice and law enforcement system. Centers which had full-time medical support and could qualify easily for third-party payments were more likely to concentrate on direct services as a way of maintaining their financial viability.

Following the passage of the Omnibus Budget Reconciliation Act of 1981, which folded the community mental health centers into an alcohol, drug abuse, and mental health block grant to the States and introduced large cuts in all human service appropriations, some States abandoned their support for consultation. Other States, however, seem to be following a trend noted by MacLennan (Rogawski 1979) in the latter part of the seventies and are funding consultation and community liaison as an integral part of services to particular populations such as the elderly and the chronically mentally ill. Sometimes, these activities are no longer identified as consultation, but are incorporated under general cooperative and coordinative activities essential for the development of comprehensive community services for multiple-disabled people, as in the community support program (Turner et al. 1977).

However, in some community support programs (CSPs) such as in Maine, consultation continues to be clearly identified. Consultees are frequently other caregivers (such as managers of residential facilities), or the community support staff may provide consultation to other mental health providers or to local government in developing CSP systems (Lamb and Peterson 1983).

While consultation and education is still a required service in the block grant, some States no longer know how much is being provided by their centers and have ceased to support a separate organizational entity. Telephone calls to a few States in fall 1984 disclosed the following: In Massachusetts, some centers have lost their consultation coordinators. In Maryland, although the large centers still retain C&E coordinator positions, in at least one large county, the position had been vacant for over a year. In its 1981 State Plan, Utah decreased consultation services considerably as the result of a decision to devote more resources to the direct treatment of the chronically mentally ill. Connecticut had added a full-time C&E coordinator for the Bridgeport Community Mental Health Center in 1982, but the State commissioner's office was unaware in 1984 of how much consultation was being provided by the centers. All centers in North Carolina still had C&E components in 1984 to which the title of prevention had been added. However, with the exception of consultation to the schools, most activity was concentrated on mental health education. Vermont had obtained a Medicaid waiver to pay for services to the chronically mentally ill, including consultation to service providers such as managers of group and boarding homes. In fall 1984, State officials in Georgia stated that centers there were required to maintain a consultation and education program and the State was supporting C&E. However, programs had been reduced as a result of cuts both in State and Medicaid funds, and the amount of C&E carried out was left to individual centers.

In Backer, Levine, and Erschul's survey of 91 centers (1983), they found that C&E was performed both within a C&E program and via other agency programs in 45 centers; the agency now performed C&E activities within other programs in 22, and the agency had a separate C&E program in 18 centers. Four centers had no C&E activities, and two centers did not respond. Out of 86 centers, 73 had a designated person in charge of C&E.

The National Council of Community Mental Health Centers found, in a survey in February 1984 (Covall 1984), that 89 percent of member centers were still providing C&E. It showed an increase in the percentage of case consultation. Consultation related to the elderly in nursing homes was a growing activity and consultation as part of aftercare was occurring, but frequently not as a discrete entity.

Among the 15 States surveyed by Larsen and Jerrell (1984), 80 percent had statutory legislation requiring mental health services and others had administrative guidelines. Of those States who specified services, 64 percent mandated consultation and education.

The distribution of consultation to different types of service providers appears to have remained fairly constant, at least through the latter part of the seventies, except that consultation to agencies serving the elderly has grown considerably. Figures for earlier years could not be compared, but NIMH data for 1976-79 show little year-to-year variation in the distribution of consultation for various consultees. Consultation to the schools remained fairly constant, accounting for about 30 percent of all consultation in each of these 4 years. The percentages of total consultation going to other consultees varied as follows: law enforcement and corrections, from 8.9 to 11.2; alcohol and drug abuse, from 6.9 to 7.9; family planning, 0.9 to 1.4; health services, 8.1 to 9.6; welfare, 5.3 to 8.4; childrens' agencies, 5.9 to 7.1; the Veterans' Administration, 0.4 to 0.6; the general public, 2.9 to 5.2; and other areas, 6.5 to 11.2. The major growth was in consultation to providers of services to the aged, which rose from 4.9 percent to 8.1 percent in 4 years. Jerrell and Larsen (1983) reported that in the eighties only consultation to schools, courts, and businesses remained constant or increased in their sample of 71 community mental health centers.

All surveys of community mental health centers in the late seventies and the early eighties emphasize that the centers' concerns with remaining financially viable have been paramount and that this has resulted, in many cases, in a reduction in C&E services (Jerrel and Larsen 1983; Backer, Levine, and Erschul 1983).

Specialization of Mental Health Consultation in the 1980s

Although community mental health consultation has been declining, this does not necessarily mean that total mental health consultation has been reduced. It is not possible to estimate the amount of mental health consultation being provided because providers are scattered and data are not collected.

Mental health consultation has been driven to some extent by ideas, as in the community mental health center program, but more particularly by the dollar. What is offered tends to be placed within the interests of the day. On the one hand, block grant funding was designed to consolidate the responsibility for planning and funding for mental health and substance abuse services under State administrations and carried with it some

obligation to continue C&E services (an obligation that has been carried out with various amounts of investment). On the other hand, there has been a simultaneous increase in coordinated initiatives to provide treatment, education, and consultation to address specific problems and populations and a rise in specialists and specialized organizations to meet these needs at both local and national levels (Backer, Levine, and Schall 1983). The development of revenue-generating services has been pursued both by community mental health center consultants and by consulting firms and individual professionals working outside or inside organizations. Although not well documented, this trend appears to have led mental health consultants to specialize in particular fields rather than to function as generalists. The following discusses some of these specialty areas.

Employee Assistance Programs

With the recognition of the high cost of alcohol, drug abuse, and mental health problems to industries, companies are increasingly willing to pay for programs to treat troubled employees, and to train managers and supervisors to identify them. Many community mental health centers, private mental health consulting groups, and individual professionals have moved to assist industries and businesses develop employee assistance programs. The bulk of this work is direct service: diagnosis, treatment, and training. Some consultation to managers, supervisors, and in-house counselors is also provided. Employee assistance program (EAP) consultation usually combines a variety of skills and tasks. An outside consultant may be asked to advise on the need for an EAP in a particular firm and to discuss various options for the development of a program. This may include helping to establish an in-house program and to continue to provide problem-solving program and case consultation to management and staff. It may also include the development of staff training or even a contract to operate the program (Roundtable 1983). Winkelpack (1984) classified employee assistance program functions into administration, counseling, advocacy, management consulting, education, and organizational development. She includes in consultation (1) consulting with both managers and staff about case or administrative problems or interpersonal conflicts and (2) consulting, as a function within organizational development, in helping management understand the organization as a social system and the potential impact on it of new developments.

Research into changes in 71 community mental health centers in 15 States found that consultation to business was one of the few areas where C&E is on the increase (Backer, Levine, and Erschul 1983). Among 544 centers responding to a national survey

conducted by the National Council of Community Mental Health Centers, 28 percent were currently providing EAPs for outside companies (Covall 1984). Backer, Levine, and Erschul (1983) indicate, however, that some centers are deterred by the need for extensive initial marketing which can be very expensive, thus requiring a program of sufficient scale to recoup outlays.

Backer, Levine, and Erschul (1983) particularly mention the employee assistance program for the skiing industry successfully developed by Bilik out of a Colorado CMHC. The EAP at the Prairie Center in Illinois services five substance abuse agencies in 16 counties and includes program development, professional counseling, consultation, and educational seminars.

An outgrowth of the need to develop consultation, education, and primary prevention into an income-generating service has in some cases resulted in a splitting off of these components into a new organization. One example is Growth Associates (Raber 1983), a subsidiary of Prairie View Community Mental Health Center, which offers organizational consultation, employee assistance programming, staff development training, and community consultation, particularly as they relate to industry and the church, both on a local and national basis.

Consultation With the Health Field

Some of the earliest mental health consultation was developed between psychiatrists and their general medical colleagues and nurses. Many community mental health centers consulted with public health nurses, general hospital emergency rooms, and sometimes with general practitioners on the mental health problems of residents of their catchment area served by the health care system. This general area, which Engel (1977) formulated as a "biopsychosocial model" of medical care, has expanded into a number of subspecialties such as consultation/liaison psychiatry, psychology or social work, biomedical psychology, and holistic health.

Psychiatric consultation/liaison programs share the common goals of improving the quality of services for patients and teaching physicians and other members of the health care team how to deliver services in a more integrated and effective manner (Trent et al. 1982). Functions include physician-oriented, patient-oriented, and nursing-oriented consultation related to the emotional aspects of physical disease, psychosomatic disorders which may be generated by mental states, or emotional reactions to physical disease and disability. Consulting related to holistic health may also center on healthy life styles. Pasnau (1982)

states that consultants in consultation/liaison psychiatry are not confined to psychiatry but may be drawn from any mental health discipline. However, he points out that there may be territorial battles between these disciplines and physicians and between psychosomatic, behavioral, and holistic medicine and general hospital psychiatry.

Health psychology has become a division within the American Psychological Association and includes consultation with general health practitioners as well as specific direct treatment such as behavior modification, relaxation therapy, postoperative counseling and teaching. Stabler and Mesibov (1984) conducted a survey of pediatric and health psychologists in health care settings and found that both groups spent between 10 percent and 20 percent of their time in consultation. Both groups found that the physicians' lack of knowledge of psychological issues and of ways to use psychologists were major roadblocks. These psychologists worked out of a wide variety of mental health, health care, and rehabilitation organizations, as well as private practice and university departments of psychology. Psychologists may be employed for their assessment and research skills (Nowicki 1981) or may develop new areas of expertise—for example, consulting with teams working on such high stress areas as intensive care units (Schneider 1980). Some psychologists are now specializing in consulting with nursing homes (York 1980).

Consultation Related to the Chronically Mentally Disabled

A major purpose for creating community mental health centers was to assist in supporting the return of chronically mentally disabled individuals to the community and to maintain them there. However, many staff of such centers in the 1960s had no experience in working with this population and, to the extent that there was a system of aftercare, it was generally connected to the State institutions. However, in the seventies and early eighties there has been increasing recognition of the need for the development of a coordinated system of care which would link together all the various elements necessary for life in the community; financial assistance, a range of residential facilities and arrangements, social support networks, sheltered work and vocational rehabilitation, day treatment, crisis management, individualized case management, and overall program planning.

In the 1970s NIMH developed the community support program demonstration with funds for States to develop systems of care and treatment and rehabilitation for this population (Turner et al. 1977). While case management has been the heart of this program, consultation and training to the other service providers,

employers, government, and citizen groups have continued as a more or less important component. Lamb and Peterson (1983) describe the range of consultation involved in these programs. Budson describes consultation to halfway houses and Peterson to residential facilities (Rogawski 1979), while Dawson and English (1975) describe consultation to nursing homes out of a medical center.

Backer, Levine, and Schall (1984) undertook a survey of services to the chronically mentally ill and found that organizational consultation to other service providers, businesses, and government may be an important source of revenue. Many States are emphasizing services for this population. Consultation is often a relatively small component and may not even be recognized as a discrete, identifiable element in the system. Rockland Community Mental Health Center in New York (1984) has developed a unified service system. Consultation to caregivers and citizen groups takes place, but it is not identified as a separate element. Under an individual fee system, consultation may not be reimbursable whereas under a more general contract it can be included as an important use of time. Consultation as an integral part of an emergency and crisis system—such as telephone consultation with case managers, hospital emergency rooms, or police—does not seem to be recognized as a discrete element in the literature, although it may well be a critical element particularly in low-cost and rural systems.

NIMH, as part of its State Manpower Development Program, funded a special health/mental health initiative in 15 States in an attempt to improve service for the chronically mentally ill. Some States included consultation. For instance, mental health professionals in Maine provide consultation to general practitioners in areas where there are few or no mental health services.

A similar initiative has been developed in 1984 to improve mental health services to mentally disturbed offenders through consultation and training to police, courts, and jail personnel.

Consultation to Lay Groups and Self-Help Groups

During the late 1960s some community mental health centers developed consultation and training to assist poverty groups in negotiating governmental and legislative power structures and to overcome "learned helplessness" (Reiff 1967; Riessman 1979). Others consulted with parent-teacher associations and mental health associations in regard to such issues as planning for school desegregation and fair housing (MacLennan 1979). During the early seventies, at the height of the women's movement, many

mental health consultants from all types of settings--CMHCs, universities, and independent practitioners--developed consultation on self-development and training in assertiveness. O'Neill and Trickett (1982) report a number of strategies to assist with community development and conflict resolution undertaken mainly in the 1970s. Kiefer (1982) describes the organizer who serves as a role model, mentor, ally, instructor, and friend assisting indigenous leaders and their peers to develop empowering skills.

Aside from these groups, two other types of groups in which the professional can play a consultative role are increasing in number. Mutual support groups consist of individuals who have similar life experiences and problems, such as widows remaking their lives (Silverman 1978). The National Association for the Mentally Ill is another such support group. Groups designed to develop supportive networks also use consultants. Gottlieb (1982) describes both these types of groups and states that the professional can help create and augment the work of these systems. Gottlieb is concerned about professionals coopting these groups, but recognizes that professionals can be helpful in assisting in problem solving, in program planning, and in providing technical assistance through evaluative research.

Groups may approach a consultant, or a community mental health center may work with a particular population to start a group and may provide consultation on a continuing basis. Membership on a professional advisory committee will often involve the provision of consultation to the group.

Consultation to the Schools

The literature on school consultation is very large and varied. Consultation is undertaken out of many different settings: internal consultation by child guidance departments such as the New York City Youth Board, contracts with outside specialists, contracts with university departments, and relationships with community mental health centers. Quinn and Wegner (1972) compiled descriptions of programs conducted out of a number of community mental health centers.

The percentage of time which community mental health centers have devoted to school consultation has remained fairly constant over the years at about 30 percent of all consultation (Bass 1982). Consultation has ranged from traditional case consultation; consultation with teachers and principals related to conflicts in their classrooms or the school or their own reactions to particular situations; consultation to the school system as a

whole; consultation on behavior modification and human engineering; consultation to student or parent groups; program development related to the treatment of emotional disturbed children in special education classes; consultation on methods to identify the nature and focus of school problems; consultation on curriculum development for human development, stress management, and improved coping skills; and consultation on school-community relations and school desegregation. Curtis and Zins (1981) and Gallessich (1982) have recently written books devoted to school consultation.

As a priority for consultation, centers have concentrated considerable resources on school consultation irrespective of whether these programs earned money, although some centers were reimbursed--particularly if they undertook the overall function of the child guidance department for the school. After Public Law 94-142, the Education for the Handicapped Act, was passed, school systems did have money to contract for services. However, it is not known to what extent the schools used this money to contract with community mental health centers and to what extent they preferred to hire their own independent experts or supply the service in-house.

The Consultants' Organizational Setting

This section examines the organizational setting out of which consultants operate and how this influences their work. Changing directions in funding methods and program emphases may move consultants into different settings. The nature of the organization will influence the consultants' motivations and the development of the consultation. Mental health consultation is offered out of three different organizational settings. First, the consultant may be part of a mental health program in the community or of a government agency charged with the granting of funds or the provision of technical assistance on community mental health. Such consultants may provide clinical or program development consultation to a variety of organizations or they may specialize in a particular aspect of consultation, such as in relation to schools or alcoholism or law enforcement. Such community mental health programs, as many authors have stated, have a programmatic responsibility to a geographic population and their priorities and choice of activities will, at least in part, be set by the overall community mental health needs of their area, city, county, or State.

Second, consultants may work independently or out of a consulting firm. Many such consultants are specialists in the problems of particular delivery systems, in general organizational

problems, in a particular mental health service method (such as day treatment or group therapy), or in the problems of a special population (such as disturbed children, alcoholics, or the elderly). Some firms may be very responsive to funding changes, hiring consultants into their companies according to the particular directions of the market.

Third, other consultants are hired to work full-time as a permanent part of a consultee's organization. These consultants may serve as specialist advisers to the director of the organization or to particular components thereof. They may or may not perform dual roles. For instance, school guidance counselors with direct service responsibilities for counseling students may also serve as consultants to teachers on the problems they are experiencing in the classroom or to their principal on the organizational or service needs of the school. Caplan (1959) initially raised questions about the feasibility of the in-house consultant, but such arrangements are common in employee assistance programs, school systems, and health-related organizations.

Consultants operating out of university departments may belong to any of these three types of settings. They may work on independent contracts, may be affiliated with a community mental health program, or may serve as staff, for instance, in a university hospital or counseling center.

Pros and Cons of the Various Settings

O'Neill and Trickett (1982) summarize some of the advantages and disadvantages of outside and inside consultants. Outsiders tend to lack firsthand experience of the system and must establish their credibility, but they possess an outside resource base which gives them greater flexibility and independence and makes them less likely to be coopted by the system. In resolving in-house conflicts they establish neutrality more easily. The in-house consultant has greater knowledge of the system, its culture, language, and politics, but may be more vulnerable and more controlled by the setting. Initially, in-house and outside consultants may have very similar problems in interpreting their utility to consultees if mental health is a new focus of the organization. However, once established, major advantages for the in-house consultants are knowledge of the agency, previously established relationships, and the ability to anticipate the need for consultation and technical assistance at an early stage in a project or problem. In contrast, Altrocchi et al. (1965) emphasized the extensive "testing" to which outside consultants are likely to be subjected. Reiser (1979) describes how in-house consultants with police programs are much more likely to gain

acceptance and learn about the inner workings of police life. However, he states that issues of confidentiality must be carefully worked out. Shellow and Newbrough (1976), on the other hand, describe how they developed a consultation program with the police, taking time to accompany them on the different aspects of their jobs and to earn their respect.

O'Neill and Trickett (1982) describe "an internal-external change agent team" with in-house and outside consultants, developed by Gluckstern and Packard in a correctional setting in an attempt to have the best of both worlds. The outsider analyzed the system and brought in specialized skills while the insider interpreted the culture and power relationships and assisted the outsider in establishing credibility. Signell (1983) also describes using an in-house teacher consultant to help her develop a parent education program around entry of children into kindergarten.

In-house consultants are initially dependent on the sponsor who introduced them to the agency. It is very important to have support from the senior executive in the component in which one plans to work. For organizationwide consultation, this will be the president or a deputy thereof; for a division or substation, it will be head of that group. However, the consultant must also gain acceptance from the day-to-day program managers who influence the program and who will be the chief consultees. In-house consultants have a position in the hierarchy and if the entry point is not senior enough, the consultant will be seriously handicapped. Consequently, while all consultees must be concerned about the organizational structure and how they stand in relationship to the powers in the agency, this is particularly important for the in-house consultant.

Sponsorship is very important for all consultants in assisting or inhibiting their acceptance by consultees. Consultees may feel coerced into a consultation and, especially if they do not trust the sponsor, they may be suspicious of the consultant also. For instance, a consultant who was referred by the local bishop to several diocesan schools had difficulty in gaining access to two of these schools. He later learned that the principals were afraid that one of the schools would have to be closed and that the consultant was assisting the bishop in making this decision.

Status conditions may vary considerably between the three types of settings. Consultants working out of community mental health programs are not generally chosen by their consultees. They are dependent on the reputation of their center and may follow an already established relationship which may or may not have been successful (Mannino et al. 1976). Independently practicing consultants will usually be chosen for their reputation and

specialized expertise. In-house consultants may be hired for their expertise and outside reputation, but once hired they must work to establish a new reputation as an insider.

In-house consultants who take on consultation in addition to an already existing role must clarify their dual relationships and responsibilities. The problems are similar to those of community mental health center consultants who provide both clinical consultation and direct treatment. Community mental health consultants seeking entry into other community service provider systems have the advantage of doing so on a collegial basis. Even though the priorities of the two organizations generally differ, they serve the same population and have some mutual concerns in regard to the mental health and well-being of that population. In-house consultants also serve the same population, but are more closely tied to the requirements and priorities of the consultees. All three, however, must be concerned with developing contracts which are responsive to the special needs of their clientele.

Most outside consultants will negotiate contracts with consultee agencies or businesses which, at least at the entry stage, will state rather specifically how their time will be used. However, some consultants are retained on a long-term retainer and government technical assistant consultants may work on an "as needed" basis. As funds become scarcer, the demand for consultants to justify their time becomes greater. Consequently, there is increasing pressure to place boundaries around consultation arrangements.

Trends in financing appear to be driving consultants to specialize. This may result in their joining the staff of human service agencies such as schools, correctional systems, or nursing home chains or they may serve as independent specialists working for many organizations. For instance, consultants on alcoholism and employee assistance programs may contract with a number of different firms.

Initiation of Consultations

Needs assessment, access to consultees, and priority setting are different for consultants operating out of different settings. Government consultants, whose role is to provide technical assistance in the development and management of community mental health services, and consultants operating out of community mental health agencies must assess the overall needs of their communities and establish priorities both between different populations and between different methods of service delivery. Community mental health consultants have been required to

conduct needs assessments in establishing priorities and developing their programs. They have used a variety of methods. They will undoubtedly consult with other service providers, government officials, and citizen groups to discover their perceptions of priority needs. They will seek out key informants, such as district nurses or local storekeepers in rural areas. They will study the demographics of their area to identify high-risk communities and, in selected instances, they may conduct sample surveys related to specific priorities. They will then consider strategies for addressing needs through community organization, consultation, public education, provider training, or direct services. They must decide whether it is preferable to develop day treatment directly or to encourage an existing center for the aged through consultation and staff development to upgrade its program to serve chronically mentally impaired elderly. They may decide that a critical effort in reducing child abuse is to encourage other agencies such as State protective services and the schools to expand their family life education and child care programs. However, in the eighties, availability of funding has become a more critical element in making these choices.

Independent consultants and consultation firms are more likely to have specific services to offer and may conduct a market analysis in the region they propose to serve. They will be concerned not only with the need but with potential demand. Will clients be interested? Do they have the funds to pay for services? What is the competition like? When this author was interested in developing a group therapy consulting practice in the Washington, D.C., metropolitan area, she contacted all mental health and family service clinics and schools in the area and met with those directors who were interested. Frequently, she was asked to survey the agency's caseload and clientele to help the director evaluate the utility of a group therapy program. Sometimes, access to the most useful part of an organization may be difficult. For instance, a psychiatric consultant was interested in developing mental health consultation to radio programs (Bernstein and MacLennan 1971). He started with program directors, but found that administrative consultation to station managers regarding staff problems was a more fruitful entry point at the time. From this vantage point, he was later able to develop consultation on programs.

In-house consultants are generally hired to provide specific types of service. They, too, will have to analyze the structure, style, and goals of their organization and consider to whom they must relate in order to be successful. They must be alert in identifying where they can be most useful and develop the need for their services.

Consultation Recordkeeping

Snow and Swift (1981) indicate that detailed aggregate and individual records should be kept of all consultation arrangements, and Mannino and MacLennan (1978) describe a number of different records frequently kept by centers.

Records are kept and reports and plans are assembled in community mental health centers for programmatic, administrative, and fiscal reasons. A consultation program will normally develop an annual plan which will detail what populations are to be addressed, what services are involved in consultation, what goals are to be achieved, and who will provide the consultations. Estimates will be made regarding the amount of time to be involved, the funds needed, how these moneys are to be derived, and the activities which are anticipated. At the end of the year a report will be prepared indicating what has been achieved in terms of activities and goals, costs, and earnings.

From an administrative point of view records are necessary for accountability, fiscal management, billing, and program monitoring and refinement. Several different forms have been in use in community mental health centers. A basic contract agreement needs to be developed for each consultation arrangement; this supplements the program plan by stating the purpose, the focus, the frequency, duration, costs, expectations, and responsibilities of all participants. Other forms may be used in centers to record daily activities and provide the basis for billing and monitoring. Some consultants use contact cards which identify the consultant and consultee by name, position, discipline and agency affiliation, and provide the date of contact, type of focus of intervention, frequency, number of consultants and consultees present, length and place of consultation, travel time, fee, goals, ultimate beneficiary, and any other data required. Other programs use consultant activity logs and checklists. These daily, weekly, or monthly forms enable consultants to note what they have been doing each day. They contain much the same information as the contact cards. Both should be designed so that they can speedily compiled into statistical reports by hand or by computer. These contact card and activity forms are also often used for billing (Mannino and MacLennan 1978).

Consultants also need records for professional purposes. They need to be able to examine how the program is progressing and what is happening in each individual consultation. Attendance records and summaries of the process and content of consultation are necessary, not only for the consultant's own development and

the evaluation of the consultation, but also for program continuity. Consultation arrangements with particular agencies may continue long after individual consultants have come and gone.

Independently practicing consultants will undoubtedly keep very different records from those of their colleagues in community mental health centers. Shore and Mannino (1982) state that for accountability purposes consultation programs must assess community needs and problems, effort made, recipient groups, program costs, and program outcomes. The independent consultant may only be interested in these dimensions in a very limited way related to the consultant's own efforts. The in-house consultant will normally substitute the needs of the company for the community and keep records accordingly.

Backer, Levine, and Erschul (1983) found that 81 of 87 community mental health centers had some kind of recordkeeping system for their consultation and education activities. Of these, 62 centers used a daily record which could be converted into monthly and annual statistics, and 19 had developed computer-based systems.

With increased pressure accountability, it is anticipated that the larger consulting programs will computerize their monitoring systems and their contracts will be more specific.

The Future of the Mental Health Consultant as Service Provider

While community mental health centers are pessimistic about the fate of consultation and education services as reported by Backer, Levine, and Erschul (1983) and by Larsen and Jerrell (1984), many States continue to include C&E as a mandated service. Support for C&E related to the chronically mentally ill and the elderly is still considered an integral part of a system of maintenance and rehabilitative services for these populations, although not necessarily delivered out of a community mental health center. Alternative community support systems, free-standing or tied into a State mental health system or county social services, may gain stronger support. The development of employee assistance programs and a spectrum of treatment and preventive services for alcohol and drug abuse, including consultation, are likely to increase.

In periods of fiscal scarcity related to human services, mutual support groups will continue to develop and to be encouraged, with their attendant need for consultation and professional support of various kinds. Interest in healthy living

likewise encourages the development of wellness programs, another area of consultation. The streams blending health and mental health in various ways also seem well established and often require consultation as a component. As long as overcrowding in prisons continues at its present rate, the need for mental health consultation to corrections facilities will also continue, whether supported or not. However, crises are often the precursors of demand.

Consultation to school systems has held steady through the years (although funding sources may have changed) and would seem likely to continue. There is, at present, increased interest in the homeless and domestic violence, with attendant requests for consultation in these areas. While there is more interest in prevention of mental illness, it is not clear to this author that Klein's expectation (1983)--that mental health consultants will become less involved in focusing on problems and increasingly predisposed to exploring with their consultees "the possibilities for joyful coping"--will actually be realized.

Although there is pressure for Government-funded programs to use less expensive staff and, wherever possible, less-qualified personnel will be trained to provide consultation, there is no doubt that there will continue to be a need for highly qualified experts. Psychologists and social workers appear to be the consultants most commonly found in organized settings, but there is no data on who consults most overall. Regardless of qualifications, mental health consultants of the future are likely to be highly specialized and the services they provide will be those which can be paid for.

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CHAPTER 13

SETTINGS, CONSULTEES, AND CLIENTS

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Introduction

Environmental measures account for more variance in behavior than measures of personality, biographic, or demographic variables together. "Individuals are not randomly distributed across different environments, but choose--as best they can--those environments most suited to their needs" (Insel 1980, p. 10). The settings in which consultation occurs shape both consultation inputs--the participants and consultation focus--and consultation outcomes. This chapter reviews the issues and discusses three critical variables that are part of the consultation environment: settings, consultees, and clients.

Issues Related to the Consultation Environment

"The environment defines the problems, contains the resources, and, through its norms, values and policies, channels the nature and direction of consultation" (Cherniss et al. 1982, p. 109). The setting has two components: the physical and social environments. The mental health consultation literature reflects less consideration of the physical environment as a variable affecting consultation than of the social environment. Issues related to geographic location and the abundance or lack of physical resources are briefly discussed below.

The physical environment refers to the physical resources and characteristics of the setting. Physical resources include locale, buildings, equipment, and grounds. Physical characteristics refer to conditions such as noise, density, light, and air quality. The influence of the physical environment on behavior has been extensively documented (Barker 1968; Glass and Singer 1972; Insel 1980; Moos 1976).

While mental health consultation around these issues has proved successful (Holahan 1977; Wilcox and Holahan 1978), the consultation literature has only recently begun to attend to the physical resources of the setting as variables affecting the consultation process. For example, the effects of national region and urban status on mental health consultation were experimentally investigated by Larsen and Norris (1982). A national sample of

mental health centers was given the opportunity, through a mailed survey, to receive free mental health consultation from an expert consultant. Results showed no significant differences in consultation outcome related to region or metropolitan status.

The importance of the physical setting for the consultation process is emerging in the descriptive comments of consultants presenting experimental results (Medway and Nagle 1982) and case histories of consultations (Alpert 1982). Settings which include multiple negative physical resources and characteristics appear to increase the difficulty of the consultation process and reduce the probability of a successful outcome. Examples include prison settings (Reppucci et al. 1973) and impoverished school settings (Medway and Nagle 1982; Murphy et al. 1980; Rogeness et al. 1977). The resources of the setting are also instrumental in program planning and problem solving.

There is some evidence that settings with ample internal resources seek mental health consultation less than those with fewer resources. In the Larsen (1982) study, mental health centers with more resources--larger budgets and more full-time staff members--were significantly more likely to decline the opportunity to receive mental health consultation than centers with smaller budgets and staffs. Some of the most useful results of the study are found in the analysis of information utilization by the consultee centers. Ideas presented by the consultant were most likely to be used if the agency could implement them without recourse to outside resources. Whether the ideas were used or not depended on their cost in dollars, staff, and time. Clearly, the setting's resources should be systematically addressed in consultation research and practice.

The social environment includes the patterns of social interaction that characterize the setting as well as the consultation process itself. Patterns of social interaction reflect the hierarchy of power and communication flow in the setting. Failure to give appropriate attention to social setting variables can lead to a breakdown in the consultation process (Bennis 1977; Berlew and LeClere 1974; Gesten and Weissberg 1982). There are three major issues related to the social environment that require the consultant's attention: (1) the setting's mission, goals, values/norms, and lifestyles (see Jacobson et al. 1980 for a discussion of these issues); (2) administrative structure and processes; and (3) issues involving time--the temporal sequence of events associated with the setting and the projected consultation.

Issues Involving Missions, Goals, Values/Norms, and Lifestyles

Discrepancies between the goals of the consultant and the mission and goals of the consultee organization—either the consultee or the administration—lead to major problems in consultation practice. Rappaport (1977) makes the point that the consultant is accountable to the leadership of the consultee organization:

Often the community psychologist will be hired by the established leaders, and almost always will have worked out a contractual arrangement with that leadership in which the goals of the organization are taken as givens, while the means for accomplishing these goals are the focus of change. Change is aimed at efficiency and effectiveness in bringing the members of the organization under social control. This may involve helping students to adjust to school, men to the assembly line, or helping community members and policemen to understand and cooperate with one another. The status quo aim of socialization to predominant social values is taken for granted, if not often made explicit (p. 131).

Problems also result when the consultant and the setting are mismatched on dimensions such as values, norms, language, and lifestyles (Glidewell 1976; Mann 1973).

Administrative Issues

If there is an inviolable rule in consultation practice, it is that administrative approval and ongoing support are necessary preconditions to effective consultation. The consultation annals provide ample evidence of the problems that arise from lack of administrative sanction or from misunderstandings between the consultant and the setting's administration about consultation goals or processes (Reppucci et al. 1973; Rogeness et al. 1977; Westermeyer and Hausman 1974b). The consultant must deal with the administrative issues involved in strategizing entry, as well as those associated with ongoing support.

The consultant also must establish a structure for informing the administration of progress and seeking ongoing support for consultation activities. The organizational levels tapped here may be different than those from which initial approval is sought. Because consultation takes place in the community and not the laboratory, goals and procedures initially agreed upon may change. Time in the setting, increased familiarity with consultee concerns, and the press of events may lead the consultant to alter the initial consultation plan. As a result, the consultant may need to

renegotiate goals and procedures periodically across the duration of consultation. In these situations, administrative sanction is continuously adapted to reflect the realities and needs of the setting within the parameters of good consultation practice.

Temporal Issues

A review of the literature suggests that one of the most important variables impacting on consultation process and outcome is rarely recognized and even more rarely controlled (Mannino and Shore 1979). Time—the temporal sequence of events—influences consultation through four interrelated but distinct processes:

1. Through the setting's external calendar—the timing of critical external events,
2. Through the setting's internal calendar,
3. During the consultation process itself, and
4. Across the outcome period during which consultee and client change may occur.

External events that impact on the setting include legislative action, turns of national and local economies, national and local political events, and organized citizen or grass roots efforts. For example, the passage and then rescission of the Mental Health Systems Act and the subsequent block grant program effected dramatic changes in mental health settings in a short time period (Stockdill 1982).

The setting has its own internal calendar. The ending of the fiscal year may stimulate a request for consultation to encumber unexpended funds, or may cause a curtailment of ongoing or needed consultation because of lack of funds. Strommen and Aleshire (1979) found consultation to be related to the setting's program planning sequence. Once annual programs were projected, consultation had very little impact. This suggests that program consultation should incorporate the lead time necessary to take account of internally fixed cycles.

The temporal variables most directly affecting consultation, and those the consultant has the greatest opportunity to control, are associated with the consultation process itself. These fall into three dimensions: the frequency, intensity, and duration of the consultation. Consultation frequency refers to the number of sessions—how many times did the consultant meet with the consultee? Intensity refers to session length—did the sessions last an hour or a day? Duration is the time period over which sessions

occur--how long did the consultant relationship continue--across weeks, months, years?

Larsen and Norris (1982) found that the frequency of consultation was unrelated to its outcome. Settings (mental health agencies) receiving two 1-day consultations showed no significant differences in outcome from those receiving one 1-day consultation. However, two sessions may be insufficient to explore adequately the possible impact of multiple sessions. There is some indication, however, that intensity may be related to consultation outcome. A number of school consultants report that consulting for an entire day in a school setting appears to be more effective than a few hours a day only (Carner 1982; Cherniss 1977). The duration of consultation also appears to affect outcome (Strommen 1975). Further research is needed to clarify these relationships.

There is evidence that the time required to implement change is a major factor in assessing consultation outcome, although this has received little attention. Larsen (1982) investigated the temporal dimension by assessing consultation outcome through followup interviews with consultee agencies at 4 months and 8 months following consultation. At the first followup interview, outcomes for centers requesting consultation showed no differences in the degree of problem solution between those receiving and those not receiving consultation. At the second followup interview, however, centers receiving consultation reported significantly higher levels of problem solution than centers not receiving consultation. The authors suggest that the process of change extends over time, and that the impact of consultation may require months to make itself felt at the requisite organizational levels. A study in a State hospital demonstrated a similar delay effect (Reinking et al. 1978). The number of new programs initiated by nurse-consultees increased during the second half of the 12-week consultation period and continued to show gains at a 6-week followup. Most evaluations of consultation outcome focus on the time period immediately following consultation. Such studies fail to take account of changes in consultee attitudes and actions that occur in subsequent weeks and months, and thus run the risk of underestimating or overestimating consultation impact.

Settings

The traditional settings for mental health consultation activities are schools, hospitals, and other health agencies. Consultative settings have diversified in recent years to include, among others, law enforcement agencies, religious settings, and settings in business and industry. Mental health consultation

activities in 11 settings are reviewed below. While some activity occurs outside these settings--for example, in media settings and within the self-help movement--the accumulated literature documenting these other consultation activities is insufficient to justify a review of setting-related trends and issues at this time.

Educational Settings

Educational settings have provided the testing ground for much of the knowledge base of mental health consultation. In a recent review of consultation outcome studies, almost two-thirds (60 percent) were conducted in school settings (Mannino and Shore 1979). Almost half of the mental health consultation publications in a recent 10-year period (1968-1978) were based on educational settings, over twice as many as the next highest category, hospital and health settings--47.3 versus 19.2 percent (data combined from Grady et al. 1981 and Mannino and Robinson 1975). The history, philosophy, and methods of the field of mental health consultation, then, have been shaped in very large part by educational settings. However, the overwhelming majority of these studies were done in elementary and middle schools. Literature documenting the effects of consultation in other school settings is limited. The following section discusses mental health consultation in three educational settings: early childhood and preschool, elementary and middle school, and high school and college settings.

Early childhood and preschool settings. The three major consultative activities taking place in these settings are at the levels of case-oriented consultation, consultation with service providers, and program consultation. Service providers receiving consultation include staff from day-care centers (Greenspan et al. 1975, 1976; Shrier and Lorman 1973), early education centers (Katz et al. 1973), and settings serving physically, emotionally, or developmentally disabled children (Allegheny County Schools 1974; Epting 1974). Common topics for caregiver consultation and training include child development, communication skills, and parent education. The child development field is seeing a growing number of early intervention consultation programs whose aim is to intervene with high-risk populations of infants and mothers to prevent the development of dysfunction. Mental health consultation provides assistance in program planning as well as in training paraprofessional parent aides (South County Mental Health Center 1984).

Elementary and middle school settings. Three trends are noted in consultative interventions in elementary and middle school settings. The first is a shift in goals from changing

individuals within school settings to changing the school system itself. The two other trends reflect this shift also: the increasing use of group or team consultation, and the expansion of consultative interventions to encompass interventions with the administration and the larger community.

Increasingly, the mental health consultation literature reflects interventions directed to changing the structures and processes of the school system itself rather than individual students and teachers within the system (O'Neill and Trickett 1982; Alpert and Associates 1982). Notwithstanding this trend, indications are that client-oriented case consultation continues to predominate consultation practice in schools. An early study found that 73 percent of the contacts of 11 school consultants in eight different communities involved case consultation (Nagler and Cook 1973). A more recent survey of 122 school psychologists shows that client-centered case consultation continues to dominate consultation practice (Martin and Meyers 1980).

If one assumes that the primary goal of any school is education, then theoretically consultants would focus heavily on educational problem solving within school settings. Yet what is often found is that consultation requests from teacher-consultees label certain students as deviant and unmanageable in the classroom setting (Cooper and Hodges 1983). The consultee seeks not so much to solve a problem as to remove the problem (read student) from the immediate setting. Often such situations reflect divergent values and norms between the consultee and the client. The values and norms of the educational system frequently favor motivated students and devalue unmotivated students whose values may differ from those of the majority. This is most striking in public secondary schools. The self-preservation demands of the administrators and teachers in the system may predetermine the scope and focus of consultation (Sarason 1971). While individual behavior change is usually the primary--and often the only--goal of case-oriented consultation, interventions at this level can also introduce or advance consultative interventions aimed at system change (Weinstein 1982).

An increasingly common approach to school consultation is intervention at the level of the service provider through the organization of a collaborative team of consultees (Carner 1982; Schmuck 1982; Weinstein 1982). The issues associated with the team approach include (1) conflict between the norms of the team and the setting, (2) the degree of involvement of the school's administration, and (3) the logistics of organizing and maintaining the group within the setting's limited time and reinforcement parameters.

Weinstein (1982) notes that the norms of educational settings favor individual rather than group approaches to problem solving --school structure is generally based on the autonomy of individual classrooms, with little staff interaction. She became frustrated with the results of individual consultation since lack of organizational reinforcement for innovation made her successes with individual teachers shortlived. Her solution was to create a team that included the principal and a cross section of the staff as members. She found, however, "that the collaborative team concept violated the prevailing norms of the school system. Both the composition of the team and its behavioral commitment to collaborative solutions made inevitable the resultant confrontation with organizational values and priorities" (1982, pp. 85-86).

The involvement of the school administration is critical in developing and maintaining consultation. The degree and nature of this involvement ranges from permission for consultation to occur to active participation of the principal or superintendent in the consultation process. There is also an informal or "shadow" administrative structure in schools made up of individuals with accrued influence whose approval and support should not be overlooked. While the formal structure is vital, it may not be sufficient (Schelkun et al. 1979). As consultative interventions succeed in the goal of changing the system, officials from multiple levels need to be involved. The changes in school procedures brought about by Weinstein's collaborative team drew the attention and concern of the superintendent. By building in formal links between him and the team, consultative gains were protected and subsequent changes facilitated. Weinstein concludes that "group consultation appears particularly suited to creating the conditions that can address system constraints in the implementation of innovations" (1982, p. 107).

There are a series of issues related to time in school settings that have relevance for consultation. Almost all of the teacher's time in the setting is scheduled with classes and job-related tasks. Release time for teachers' involvement in consultation may entail additional funds for employing classroom substitutes, or it may require other teachers to cover the classroom. Both solutions have potentially negative implications for consultation success. If the school lacks the resources to free up teachers' time, the consultant may be limited to working only with those teachers willing to volunteer on their own time. Gesten and Weissberg (1982) solved the problems of restricted school time, teacher motivation, and reinforcement by arranging with a university to award tuition-free graduate credit for participation in consultation. A further temporal issue has to do with the cycles within the setting. There appear to be particular time frames

which generate more consultation requests in schools. For example, report card time, parent-teacher conference time, and promotion or retention decision time tend to increase consultation utilization, while the early and ending weeks of the school year are low utilization periods (Jacobson et al. 1980).

As school consultants have expanded their focus from individual students and teachers to the school system itself, the levels of consultative intervention have also expanded to include administrators, parents, and the larger community. Hodges and Cooper (1983) describe a case in which consultation with parents concerned about preadolescent sexual behavior led to plans to develop a youth recreation center in cooperation with local churches. A classic case which began as program consultation to a school in Ann Arbor, Mich., dealing with issues of overcrowding and desegregation subsequently spread to encompass minority parents, a large minority neighborhood, and ultimately, the larger community (Davidson 1979; Swift 1982). Political and social processes brought change at each level of intervention.

Higher educational settings. Mental health consultation in higher educational settings has received relatively little attention. It has been estimated that mental health consultation publications based on elementary and middle school settings outnumber those based on high school settings by a ratio of 9 to 1 (Medway and Nagle 1982). Reports of consultation in colleges and universities are even rarer.

A major difference between elementary schools and higher educational settings is the shift in autonomy experienced by the client population. As adolescents pass through high school, they take increasing control over aspects of their lives formerly determined by parents and teachers--such as modes of dress, selection of courses, peer associations, and school attendance itself. This shift leads to conflicts with teachers and administrators over dress codes, curriculums, discipline, and truancy (Cherniss et al. 1982)--all common topics for mental health consultation in high schools. The experimentation with alcohol and drugs and the sexual exploration associated with adolescence also trigger requests for consultation from parents and teachers (Hodges and Cooper 1983).

Aside from consultation content, there are other major differences between elementary and high school settings. Medway and Nagle (1982) provide an insightful analysis of four such differences: physical environment, organizational structure, student population, and relations with the community. "The sheer size and complexity of high schools tend to block communication, increase interpersonal distance, and add to a general sense of

powerlessness" (1982, p. 146). Reflecting this increase in complexity, the consultation in high schools may include the student population as active members of consultation teams (Cherniss et al. 1982).

Mental health consultation at the college or university level is frequently directed to improving the skills of dormitory counselors or residence hall assistants in dealing with students (Auerback 1976; Davis 1974). Mental health consultation with administration or faculty around program, faculty, or curriculum development appears to be a difficult and complicated undertaking. Bardon (1982) spells out the problems in a thorough and candid case study of his attempts to promote faculty development in a school of education within a university. His reflections on what he would do differently are instructive:

I would report to the entire faculty more often
I would discuss problems in offering consultation services with the faculty on an ongoing basis so that rumors and false assumptions about the consultant's work do not develop. I would reorganize the entire project to include less faculty time in order to cut costs . . . I would be more open about my role as a consultant to committees and extend my services to committees on which I did not myself serve. I would work harder to keep the university's administrators informed of my activities. I would try to help them understand the differences between consultation from a department chair--who must make hard decisions about faculty members and sit in judgement on them--and a consultant whose purpose is to help faculty do what they want to do in their own way, regardless of merit pay requirements, tenure decisions, administrative ratings, and all the other activities that prevent chairpersons from being collaborative and neutral consultants (p. 206).

Hospital and Other Health Care Settings

Two utilization trends are apparent in the practice of mental health consultation in hospitals and health care settings: first, mental health consultation is underutilized; and second, utilization appears to be directly related to the availability and visibility of mental health personnel. While it is well known that a high proportion of medical patients suffer from emotional problems, the treating physician may either not recognize the psychogenic aspects of the case or may fail to make a mental health referral (Cavanaugh and Flood 1976-77; Mendel and Klein 1973; Shevitz et al. 1976). Part of this underutilization of mental health consultation comes from a shortage of mental health professionals in

hospitals and other health settings. Adding mental health staff resources increases requests for consultation (Krakowski 1974; Mendel 1974).

Another source of underutilization is physician resistance (Steinberg et al. 1980). In a survey of 244 physicians in a mid-western teaching hospital, almost all (99 percent) of the respondents endorsed the concept of readily available psychiatric consultation services in large general hospitals. However, in a preceding 12-month period, less than 5 percent of their private hospitalized patients had received such consultation (Cavanaugh and Flood 1976-77). A 12-month study of utilization of psychiatric consultation in a university-based primary care center showed that only 5 percent of patient visits to the medical clinic resulted in requests for consultations. It is notable that almost all the nurse practitioners and social workers in this setting sought consultations, in contrast with the physicians (Slaby et al. 1978).

The reasons underlying the reluctance of physicians to seek mental health consultation have not been systematically identified, although several studies bear on this topic. A survey of 56 family practice residents in 23 States revealed deficits in the residents' knowledge of medical psychology and their unfamiliarity with mental health consultation to medical patients (Shienvold et al. 1979). Krakowski (1973) suggests that nonpsychiatric physicians may fear failure in treating medical patients who present them with concomitant emotional problems. This fear may lead to a variety of defenses blocking these physicians' successful utilization of mental health consultation. On the other hand, the referring physician may have expectations about the consultation process based on the generally accepted "rules" of consultations in medicine and surgery (McCue 1982). If the mental health consultant is unfamiliar with these "rules," a failed consultation may occur, with a reduced probability that the physician will seek mental health consultation in future, similar cases. Guggenheim (1978) lists five factors determining requests for mental health consultation on the part of internists and surgeons: perception of need, prior attitude and experience, projected image, availability, and cost/benefit ratio.

The mission, goals, and norms of hospitals and other health care settings revolve around curing disease and saving lives. Problems of conflicting goals and staff morale arise when cures or lifesaving measures become impossible because of chronic disease or terminal illness. Both case and program consultation can be effective in resolving conflicting staff attitudes and treatment procedures around the problems these cases present (Brantley et al. 1981; Drotar 1975).

The utilization of mental health consultation in health care settings is influenced by the traditional professional hierarchy. Physicians seek the expertise of other physicians for consultation; nurses seek the expertise of other nurses, and so on. Professional turf issues are clear in each discipline's continuing education requirements. One study found physician resistance to the use of psychiatric nurses as mental health consultants in emergency room care, even though the nurses successfully managed two-thirds of all psychiatric referrals (over a 5-month period) and needed only telephone consultation to manage the majority of the remaining third (Severin and Becker 1974). Segmentation of responsibilities and tasks by discipline leads to fragmentation of services, to the detriment of patient care. The strategy of teaming consultants from mental health and medical disciplines leads to improved patient care and lessens professional turf issues. For these reasons, the interdisciplinary consultation team has become a standard approach to mental health consultation in hospital and other health settings (Barsky and Brown 1982; Drotar 1975, 1976; Froese et al. 1976; Seitz et al. 1976; Streifel et al. 1976).

Temporal issues affecting mental health consultation in medical settings are related to the internal demands of these settings. Heavy patient caseloads, the press of scheduling diagnostic and treatment services, and reimbursement realities do not facilitate the use of time for patient conferences or communication between caregivers. On the other hand, consultation may promote effective communication within the time parameters imposed by the setting (Nixon 1975; O'Neill and Trickett 1982).

Cross-Cultural and International Settings

The major setting-related problem associated with cross-cultural consultation is that of discrepant values, norms, and lifestyles. The discrepancies arise from differences in the ethnic and cultural backgrounds of the participants making up the consultation triad (Westermeyer and Hausman 1974a). Frequently, the client and consultee share a common ethnic background which differs from that of the consultant. This may result in the consultation field's equivalent of the "ugly American syndrome." Hilliard (1974) describes the efforts of American educators to set up an American-style, semiautonomous school district in a country where such a structure is alien to local history and custom. Massive delays, confusion, and conflict between consultants and consultees plagued project implementation. The consultant whose ethnic/cultural background differs from that shared by the clients and consultees runs the risk of being ineffective (Owen 1977). Educational consultants to the Third World have lost esteem because of their assumption of inappropriate roles in the context

of the setting--such as taking responsibility for direct management (Bousquet 1976). In view of these issues, it has been suggested that the appropriate role for a professional expert who is not native to the consultee culture is that of technical assistant (Urion 1974), with administration left to resource persons in the native culture.

Geriatric Settings

Because mental health consultation in settings dealing with older adults is relatively recent, there are few cases available that document the role of setting variables. Two trends are suggested from a review of the literature. First, consultative interventions in this setting appear to be exploratory. Second, interventions are directed primarily to service providers.

The exploratory nature of these consultative interventions is seen primarily in a lack of consensus around consultation goals, but also in activities directed to carving out a professional role. The issue of consultation goals relates to differences of professional opinion as to the appropriate sites for care of the elderly who are experiencing distress and who are unable to maintain themselves in the community. The question is whether such care should be delivered in mental health or non-mental health settings. Felton (1982) makes the point that many nursing homes are little more than dumping grounds to warehouse the elderly released from mental hospitals in recent years, and argues for the superiority of mental health settings as care sites. Several studies, however, consider consultation a success if elderly residents can be maintained in nursing homes by upgrading the skills of the caregivers in identifying and treating patient distress. Freedburg and Altman (1975) report a reduction of patient transfers to mental facilities as a result of a 2-year consultative relationship with a nursing home. York (1976) also reports that consultation and training with nursing home staff resulted in a reduction of patient admissions to State hospitals. Daggett and his colleagues (1974) describe a mental health team approach to consultation with nursing home staff members to improve the care and treatment of residents within the nursing home. Mental health professionals in the emerging field of geriatrics have yet to reach consensus on which has higher priority: maintaining distressed elderly residents in nursing home settings, or shifting their care to mental health facilities.

The second trend apparent from a review of the literature is that consultation to the service provider predominates, followed by case-oriented consultation and then program consultation. The development of geriatric facilities to provide more than custodial

care is relatively recent. The emerging science of gerontology is improving the skills and expertise required to maintain residents in settings designed for their care instead of consigning them to custodial facilities. Developing the comfort level and skills of nursing home staff appears to be a growing activity in this setting.

Government Settings

The key setting variable in mental health consultation with governmental personnel is the administrative hierarchy, with its associated bureaucratic processes. The changing political and economic mandates characteristic of election-year personnel shifts generate multiple and overlapping levels of administrative responsibilities. The consultant is faced with sorting out the official responsibilities and informal functions of consultees within targeted agencies. Such problems can become the focus of consultation, as in conflict negotiation between government agencies (Walton 1968). Since government projects often utilize private contractors and subcontractors, consultants involved in these projects must develop skills to manage multiple levels of responsibility (Otto and Smith 1973). Feinstein and his colleagues employed creative methods of consultation for collaboration between the city of Detroit and Wayne State University around the identification and resolution of city problems (Feinstein and Musial 1977; Feinstein and Seaver 1977).

The problems posed by labyrinthian bureaucratic structures and procedures are compounded when consultation crosses national boundaries. In a case cited earlier (Hilliard 1974), a group of American educators were brought to Liberia through the joint efforts of the American and Liberian Governments to assist in setting up a semiautonomous school district. The model for the school district had been proposed by foreign aid technicians who did not have extensive knowledge or experience of Liberian culture. Bureaucratic procedures, power struggles between the various levels of government involved, and the differences in culture between consultants and consultees created major problems in implementation.

The inertia in governmental agencies makes it difficult to plan and implement change. O'Neill and Trickett (1982) describe the problems of an official of the U.S. State Department charged with making major changes: "The State Department was so ponderous and bureaucratic that it was referred to as the 'fudge factory' by its detractors. Lines of authority crisscrossed throughout the organization, making it difficult for someone who gave an order to discern its implications throughout the department" (p. 44). Mann (1983) notes that resistance is a systemic part of

the consultation setting, and that there is ". . . an inverse relationship between the accessibility to a consultant of components of an organization and the standing of those components in the organization's power structure. Organizational components with less social power were more accessible than those with more social power" (pp. 105-106). These considerations are particularly relevant for government settings, in which the more accessible civil servant may have less authority than the less accessible or more transitory political appointee. In contrasting two cases of consultation with government agencies, one successful and one unsuccessful, Westermeyer and Hausman (1974b) stress the importance of explicit task definitions, access to both the setting's decision-makers and its target population, adequate logistical support, and control by the consultant of the consultation schedule.

Administrative issues affect the morale and functioning of consultee staff of governmental agencies as well as consultant effectiveness (Hagen and Weiland 1973). Polk and MacLennan (1975) have detailed the conflicts that State and regional government officials experience when their jobs place them in multiple roles. Regional mental health officials had difficulty deciding where their allegiances lay in providing technical assistance to and monitoring the performance of public and private agencies. The question of concern was: Who is the client for these officials --the government agency that pays them, or the agency/consultees to whom they provide assistance?

Another feature of mental health consultation in government settings is the potential for influencing large numbers of clients. The mental health field's recent emphasis on health in the workplace provides an example. A disease prevention/health promotion program for Federal agencies reached 2,600 employees (Melchiodi 1973). The capacity of government settings to mobilize large numbers of employees for consultation and training activities lies in the authority of the government to command participation of entire units, departments, or divisions. Exercise of this command theoretically simplifies the consultant's task in mobilizing trainee cooperation. However, arbitrariness in practice can nullify the gain--forced attendance may generate resistance to the consultation.

Industrial and Business Settings

A major administrative issue in this setting is the relationship between management and labor. The mental health consultant must negotiate the consultation contract so as to take account of the concerns of both parties. Otherwise the consultant may be identified as an agent for either labor or management, with a

resulting loss of credibility and effectiveness. Consultants in these settings may be asked to mediate conflicts between management and labor (Blake et al. 1965), as well as provide employee assistance programs (EAPs) (Aronson et al. 1976; Foote and Erfurt 1980), or train labor-management staff in mental health-related activities (Akabas 1982).

This setting has experienced an increase in the amount of mental health consultation over the last 5 years. This increase is directly related to the reduction in Federal funds for consultation and education programs in mental health agencies (Snow and Swift, in press). Prior to these funding reductions, less than 10 percent of all consultation and education staff hours were spent delivering services to business and industry (Hassler 1980). In a recent survey of 186 mental health agencies, Backer et al. (1983) documented the impact of the budget cuts and the emergent prominence of mental health consultation to settings in business and industry. One-fourth of the agencies responding ranked these programs as among their primary consultation activities, and 42 percent cited consultation to private industry as an important source of revenue for the agency. A second major survey (NCCMHC 1982) found that, of 544 community mental health centers, one-third reported that they currently have or are developing EAPs and an additional third report plans to develop them. EAPs provide a wide range of consultation services to business and industry, including supervisor training, employee education, and management consultation. Consistent with this setting's profitmaking goal, EAPs are aimed at increasing productivity and reducing inefficiency, accidents, and absenteeism.

Mental health consultation with business and industry reflects a relative absence of the discrepancies found in other settings in the goals, values, and norms of the consultant, consultee, and client. The goals of all three revolve around increased productivity and profit. The focus is on reducing those behaviors and managerial problems that interfere with profitable operations. Consultations around quality of work life (Glaser et al. 1976), job adjustment (Leeman 1973), and job enrichment (Kraft and Williams 1975) are designed, ultimately, to increase productivity. While mental health consultation in these settings generally avoids consultant-consultee clashes about goals, conflict may occur around consultation methods. For example, Bennis (1977) reports a case in which management objected to the methods used by the consultant—group processes and human relations exercises. As a result the consultation was abruptly terminated.

Law Enforcement Settings

Divergent values and norms, problems in eliciting and maintaining administrative approval, and restricted time available in the setting for consultation and training are the major issues the mental health consultant must deal with in law enforcement settings. For reasons of history, experience, security, and role demands, law enforcement personnel form tightly knit professional groups whose values, norms, and lifestyle differ from that of the public (Mann 1983; Reiser 1972; Snibbe and Snibbe 1973). Police and correctional officers may regard mental health professionals as "do-gooders" or "bleeding hearts."

External-internal consultant teams have been used to defuse the issue of discrepant consultant-consultee values and norms (Gluckstern and Packard 1977). As O'Neill and Trickett (1982) point out, "The person recruited from within the setting can help the team read the environment and also confer legitimacy on the team's activities. The outsider brings not only expertise lacking in the setting but also the degree of objectivity that we have associated with outside consultants" (1982, p. 31). A discrepancy may also exist between the attitudes and behaviors of law enforcement consultees and those judged appropriate or necessary by the command structure of the setting or by citizen pressure groups. A recurring issue in many communities is that of alleged "police brutality" in interactions with citizens. In these cases the consultant's status (inside-outside) is less pivotal than the outside community forces pushing for change. The consultees' resistance to change is proportional to the amount of change required. The greater the gap between existing attitudes and behaviors and the sought-after change, the more resistance there is (Fairweather et al. 1974). Shellow (1965) was given only 6 hours to train police officers in suburban Maryland to handle a civil rights demonstration. He elected not to attempt attitude change, opting instead to focus on reinforcing appropriate professional role behavior. By providing models of police roles in crowd situations, Shellow capitalized on group pressures for conformity and reduced the conflict between group norms and private attitudes. The civil rights demonstration took place without disruptive incidents.

An important setting-related variable is administrative approval of the consultation by the command structure. Outside consultants frequently report their consultation is met by interference, resistance, or hostility from one or more levels of the setting's administration (Cohen et al. 1976; Reddy and Lansky 1975; Sebring and Duffee 1977). As with discrepant values, one approach to reducing administrative resistance to consultation is for the outside consultant to team up with an inside expert. Gluckstern and Packard (1977) report a case in which the

consultant teamed up with a police officer to conduct consultation in a police department. This gave him the advantages of both peer consultation (Swift 1981) and outside expertise. Other investigators have also reported successful consultations with police based on this paired external-internal model (Bard and Zacker 1976; Snibbe and Snibbe 1973).

Another approach to reducing administrative resistance and discrepancies between values and lifestyles is to become an "inside" consultant. The consultant has many advantages in this role. In the eyes of police personnel the consultant ceases to be one of "them" and becomes one of "us," with increased access to the setting's resources and potential impact on the setting's processes and decisions. Over time issues of trust and acceptance are positively resolved. Reiser (1972) has detailed the advantages and disadvantages of this approach in an account of his experiences as an inside consultant with the Los Angeles police department. Fields (1977) reports parallel benefits and concerns for inside mental health consultants in a county jail.

While time is a crucial issue in all settings, it is particularly critical in police consultation. The rigidly formatted schedule of shiftwork, the pressure to respond to unpredictable and fastbreaking events, the militaristic organizational structure, and the characteristically understaffed situation most urban departments find themselves in today combine to restrict the time available for consultation and training. In a consultation project conducted by Swift (in press) involving the identification of sexual child abuse, police agencies retracted initial agreement to commit personnel to a 26-week training curriculum. A 100-year flood, community controversy around issues of desegregation, and personnel cuts resulting from reduced budgets forced abandonment of the original consultation schedule. In the end, a half-day workshop was the maximum time committed. It is notable in this case that police subsequently identified significantly fewer cases of sexual child abuse than the agencies receiving more intensive (1-day) consultations or those receiving consultations of longer duration. The constraints posed by time issues in this setting are echoed by a number of consultants (Mann 1983; Reiser 1972; Shellow 1965).

Typically, an outside consultant has only "one-shot" at attempting to effect change in police personnel. Given that consultation aimed at attitude change appears to require a higher consultation frequency and duration than consultation aimed at behavioral change (Rappaport 1977), the consultant must decide how best to use the limited time available. Shellow's (1965) choice of reinforcing professional role behavior in such a situation turned out to be an effective, short-term solution.

Because of the militaristic command structure and the values and norms bred by law enforcement settings, consultees are accustomed to training experiences that teach through didactic presentations and field testing. The human relations approach of many mental health professionals, in which small group experiences and personal sharing are emphasized, is alien to many law enforcement settings. Consultants to police must analyze the receptivity of the setting to the consultation model proposed, and adapt it to best satisfy the restrictions imposed by time, discrepant norms, and desired consultation outcome.

Military Settings

Physical and social environmental concerns are compounded in military settings, where physical conditions may be modest or even primitive--as in combat. The three aspects of the social environment cited earlier--mission, norms, and lifestyle--are different for the military than for the civilian population in general, and the mental health professional in particular. Military settings emphasize combat readiness, instant obedience within the established chain of command, subordination of feelings to the sacrifices and demands of military goals, and the maintenance of tight security to ensure the secrecy of military operations. The administrative structure, a paradigm of rigid bureaucracy, presents special problems for the mental health consultant (Jeffer 1977). The activities of military training, combat, and routine assignment are structured within specified time parameters. For all these reasons the most common model for mental health consultation in military settings is use of an inside consultant.

Mannino and Shore (1975) review two studies in which unit group mental health consultation is reported. In this model "mental health hygiene technicians functioned as consultants to unit commanding officers, assisting them in coping with behavior problems in their commands" (1975, p. 10). The consultation activity appeared to combine consultation and direct service. One of the studies reported improvement in the military performance of two-thirds of the enlisted men involved in the consultation program. The second study was more ambitious in its evaluation. "It was believed that the consultation program would significantly reduce unit rates of AWOLs, court martials, Article 15s, and requests for mental health services. After 6 months the evidence was inconclusive in support of the program's predicted impact" (1975, p. 10).

Minority Settings

The discrimination associated with minority status in this country affects the goals and methods of mental health consultation in these settings. Discrimination carries a legacy of hostility, mistrust, and deprivation of resources that has implications for interactions between the members of the consultation triad. Westermeyer and Hausman (1974a) provide an analysis of potential problems resulting from consultations in which the ethnicities or backgrounds of the consultant, consultee, and client differ. Gesten and Weissberg (1982) attempted to implement a cognitive behavioral approach to social problem solving in an inner-city elementary school. As white professionals working in a black community, they were confronted with a variety of concerns from the parent advisory council. Would black children be used as guinea pigs for a testing program run by white investigators? Would project staff be drawn from the neighborhood? Was there a commitment to follow through, or would the program come and go as so many others had? Was this to be a one-shot research study? "Our hurried, pressured contacts with parent leaders in the inner city resulted in a failure to recognize what they felt to be their greatest need: increased social work services" (p. 224). This need is echoed repeatedly in the literature. Advocates for minority groups argue that traditional mental health services are inappropriate in the face of the immense social, economic, and educational needs of minority populations (Barrera 1982; Manson and Trimble 1982; Moore 1982).

A common finding for cases of mental health consultation in minority settings is that consultation is more frequently requested when communities are in transition: "In times of change, minorities are vulnerable" (O'Neill and Trickett 1982, p. 184). Consultants working in minority settings are advised to ally themselves with natural helpers to maximize the reach and effectiveness of interventions. Wong (1982), in projecting strategies for improving mental health programs for Asian and Pacific Americans (AAPAs), recommends that AAPA community coalitions be supported and funded to establish mental health services for their communities. Gottlieb's (1983) work in the area of social support reinforces this theme:

Unique sources of help exist in minority communities . . . they represent expressions of sociocultural patterns, religious belief systems, or the popular culture among local residents. Agencies that serve these communities are advised to develop methods of identifying these indigenous resources. They should try to understand how they function and try to enlarge their work while preserving their cultural traditions (p. 200).

Religious Settings

Traditionally, religious settings have not been major recipients of mental health consultation. In a survey conducted a decade ago only 15 percent of 400 mental health centers contacted reported having active programs with their local clergy (Carlson 1976). The emergent interest in informal support systems and natural helping networks has stimulated efforts to link the supports found in religious settings with those of other caregiver networks in the community (Biegel 1984; Gottlieb 1981). The clergy play critical roles as community caregivers. They provide vital support to their parishioners at times of developmental life passages and crises. Birth, marriage, death, domestic conflict, divorce, alcoholism, and drug abuse are some of the areas of concern to both clergy and mental health professionals.

Carlson (1976) contrasts two ways in which mental health professionals work with clergy. The mental health helper may lecture or may provide consultation to clergy about how to handle people with emotional problems. These activities are usually conducted in mental health center offices, and only occasionally in churches. Or the two professional groups can work collaboratively in programs "that suggest the clergyperson, the congregation, the synagogue, or the parish is a resource in the continuing well-being of both the troubled person and the person who may never need direct psychiatric intervention" (Carlson 1976, p. 87). Collaborative programs capitalize on the unique role and authority of clergy to promote preventive approaches and connect people with resources outside the mental health center. These programs, conversely, are usually conducted in churches or other community settings.

As part of an experimental analysis of collaborative work with informal caregivers, 29 clergy, spiritualists, merchants, and social club owners in East Harlem were asked to keep records of their contacts with people seeking help for drug problems (Leutz 1976). Half of the caregivers were provided with a referral guide for alternative treatment services for drug problems, and verbal information about each of the services. The results showed that the caregivers who were given referral information were almost twice as likely to refer people who approached them for help with drug-related problems as the other caregivers in the study (50 percent vs. 28 percent). The clergy and spiritualists were the most active of the informal caregivers in making referrals.

A municipal court program utilizing ministers as counselors for alcohol offenders also used a collaborative approach. Six ministers held monthly team meetings to discuss cases, with

sessions facilitated by co-leaders (a minister and a psychologist). Fifty-two offenders, their family members, and friends were counseled by the ministers. Results showed alcohol convictions to be significantly reduced for clients in the 12 months following counseling, compared with the 12 months preceding counseling (Swift and Beverly, in press).

There are relatively few experimental studies documenting the effects of mental health consultation in religious settings. An early control-group study explored the effects of consultation and training of extended duration (46 sessions). Clergy receiving the consultation significantly increased their sensitivity and skills in responding to persons experiencing grief (Hommen 1972). Strommen (1975) varied both content and time parameters (frequency and duration) of consultation to clergy involved in one-to-one counseling with youth in Minneapolis-St. Paul. He concluded that: (1) clergy exposed to consultation gained in "accurate empathy, nonpossessive warmth, and genuineness," with slightly greater gains for those whose training was of longer duration; (2) the program lessened client-youth concerns about common high school problems; and (3) clergy counsel a large number of people (the 34 clergy counseled approximately 4,000 youth over 12 months).

Social Agencies

"Who gets what? That may be the quintessential question in community life, rivaled only by a related question: Who decides who gets what?" (O'Neill and Trickett 1982). The staff of social service agencies decides who gets specific services. The power to distribute life resources such as food, housing, and health care, and to influence family matters such as child custody, set up social agencies as arenas for conflicts of values and political control. Administrators and staff are caught between their clients' needs and inadequate availability of resources. Publicly funded social agencies are chronically understaffed with workers who are underpaid and often insufficiently trained for their responsibilities.

Social service/welfare departments represent one major and very large potential recipient of consultation at both the county and State levels (Hasenfeld and English 1974). These organizations are burdened not only with ever-changing policies, procedures, and eligibility requirements (Cooper 1974), but also with large numbers of clients who reflect a wide range of problems. Caseloads are large and staff resources limited, leading to staff burnout. Staff members of these agencies are forced to maintain reactive behaviors and therefore tend to request consultation only

under the most dire circumstances (Weisbord 1979). Accordingly, consultants are well advised to expect a "crisis" environment with extremely short time frames for problem resolution. Further, consultants will find themselves "stuck" at a case consultation level even though program or administrative consultation is more needed. Perhaps the greatest challenge is maintaining an ongoing presence on which to build competence and trust for long-term consultative interventions (Denner and Price 1973).

Issues that complicate consultation in these settings include differences in background and ethnicity between the consultant, consultee, and client (Westermeyer and Hausman 1974a) and discrepant goals between the consultant (i.e., system change) and the setting (i.e., training workers to serve clients faster). The consultant's values may rest more with helping disadvantaged groups gain resources than with maintaining the system as it is (O'Neill and Trickett 1982). A pervasive obstacle to consultation incorporating innovation is the resistance characteristic of the power structure of social agencies, particularly those that are publicly funded (Graziano 1969).

Consultees

The expansion of mental health consultation into nontraditional settings and the field's increasing awareness of the importance of setting variables have focused attention on the consultee as a significant contributor to consultation outcome. The size of the consultee group, the level of intervention, and the characteristics of the consultee organization are all key variables in planning and implementing consultation interventions.

Size of Consultee Group

A major evolution in mental health consultation and practice has been a shift in the size of the consultee group. Historically, individual case consultation has been the dominant model, particularly in traditional settings--hospitals and other health settings and educational settings (Mannino and Shore 1975). As consultation methods, settings, and skills have developed and expanded, group consultation has increased in frequency. This increase appears to be driven by both ideological and economic developments.

The last 10 years have seen an increasing emphasis on preventive approaches to health and mental health problems. This emphasis is reflected in a shift in mental health consultation goals from changes in individual clients and consultees to changes in

social institutions and systems. The field of education provides an example. Over a decade ago Nagler and Cook (1973) noted that 75 percent of the contacts of a sample of school consultants involved case consultation. They argued that the rate of psychological casualties could not be expected to decrease unless consultation began to focus on changes within the school system itself. Consultation directed to helping individual children with problems in school settings has little impact on changing the systemic forces that contribute to the development of school problems. In order to reduce the incidence of such problems in the youth population, interventions must extend beyond individual children to school systems, the larger community, and relevant State and Federal policies, regulations, and legislation.

Economic factors also support the growth of group consultation. Individual client- or consultee-centered consultation requires greater inputs of professional time per client/consultee served than group consultation. Administrators of health and human service programs in the 1980s have fewer discretionary dollars for consultation and training than their counterparts of the 1960s and 1970s, so they may be more receptive to group than individual approaches to consulting with and training agency personnel.

In general, group consultation is the model of choice when (1) the goal is prevention rather than treatment (Nagler and Cook 1973), (2) the target for change is the system rather than a single client or consultee (Cooper and Hodges 1983), and (3) there is a need to make maximum use of consultant resources--i.e., time or budget is limited, or the consultee group is large. On the other hand, individual consultation is likely to be the model of choice when (1) the goal is diagnosis or treatment, (2) the target for change is a single client or consultee, and (3) the availability of resources does not preclude the one-on-one approach. Hodges and Cooper (1983) also cite theme interference reduction (Caplan 1970) as important in the consultant's decision to consult with individuals rather than groups:

Individual-process consultation is strongly effective as an intervention depending on (1) how central the personality dynamic is for interfering with effective job functioning, (2) how often in the work situation client characteristics activate the consultee's interfering dynamics, (3) the centrality of the consultee in the system, and (4) staff turnover. At times an effective reduction in a theme interference (or stereotype) can be helpful for hundreds of clients served by that consultee (Hodges and Cooper 1983, p. 35).

Given that prevention ideology and the economic realities of the 1980s foreshadow the increasing use of group consultation, it becomes important to identify optimum group size and problems associated with the group model.

The optimum size for group therapy is generally thought to be from six to eight participants. However, group therapy and group consultation differ on a variety of dimensions. In group consultation, educational goals predominate over those directed to modifying disorder (Altrocchi et al. 1965), giving wider latitude for larger (e.g., classroom-size) groups. Other key differences between group consultation and group therapy--the focus on professional rather than personal issues, the consultee's explicit freedom to use or not use what is offered--also support the use of larger groups for consultation purposes. There is a need for research to clarify the range of group size for effective mental health consultation.

Three problems have been identified with the practice of group consultation. They are the status of consultee participation (voluntary vs. involuntary), the time required to establish trust, and the dangers inherent in group biases. Mann (1983) points out that group consultation may be less voluntary than individual consultation. One of this chapter's authors, Swift, encountered this problem in consulting with a city department. After following accepted procedures for arranging a training session, she was pleased at the 100 percent staff turnout. As the session progressed, she became increasingly aware of inattention, indifference, and even hostility from some of the participants--responses which had not occurred in previous workshops with similar city departments. The supervisor subsequently cleared up the puzzle. He explained with pride that in order to guarantee maximum participation, he had cancelled all vacations, compensatory time, and sick leave for the day. In this case the capacity of government officials to "command cooperation" sabotaged the ambiance of the training.

Another problem is that it may take longer to build an environment of trust in group vs. individual consultation. Gesten and Weissberg (1982) noted a reluctance to role play on the part of teacher-consultees. They were particularly distrustful in initial sessions among their peers. O'Neill and Trickett (1982) review the magnification of biases that occurs in groups. This process leads members to take more extreme stands on issues and to interpret them so as to conform to group consensus. While this process may lead groups to decisions or actions inimical to their interests, shared assumptions may also contribute to group cohesion and continuity.

In an experimental comparison, group consultation was found to have some advantages over individual consultation. Tobiesen and Shai (1971) found no differences in client outcome between the two, nor did the teacher-consultees rate one type as more useful than the other. However, group consultation was significantly more successful than individual consultation in achieving two program objectives--providing teachers with general information about child development, and generating discussion and exchange of ideas among teachers in each school.

These findings confirm basic learning principles: social interaction around new information, extrapolation, repetition, and rehearsal serve to reinforce learning. Group consultation participants have the opportunity to ask questions, respond to other participants' concerns, and continue discussions outside the formal consultation forum. Individual consultation leaves the consultees' peers with no direct information about what went on in the consultation. Thus, individual consultation is less effective and efficient than group consultation in capitalizing on the synergistic effects of social interaction on learning.

Level of Intervention

The level at which the consultant enters the system varies according to whether the goal is prevention or treatment. Mental health consultation may be directed at individuals, groups, organizations, communities, or systems, or any combination of these levels. The inclusion of prevention in consultation goals has led directly to the addition of communities and social systems as appropriate intervention levels.

The process by which consultation has spread from the initial level of entry to multiple levels has followed a standard sequence of order in traditional settings. Case consultation has usually been the first consultative intervention, followed by interventions targeted to service providers, with program and administrative consultation appearing later in the intervention sequence. As consultation has increasingly embraced prevention goals and system change strategies, the standard sequence of intervention activity has tended to reverse direction. Consultation in settings in which advocacy or citizen leadership is prominent tend to be initiated at the level of the community or system. These interventions may then spread to consultation at organizational and administrative levels within specific community agencies in order to implement the changes sought by community groups. Consultation with community groups seeking to improve police-community relations typifies this reversal of the traditional sequence. Such consultation, initiated at the community level, may then lead to

consultation with police administrators to assist in planning agency response to citizen concerns. Consultation at the level of the service provider may then follow--in this case, training police officers in community relations.

Consultee Characteristics

Consultee characteristics have importance for the consultation process at every level. There are few experimental studies that link these characteristics to consultation outcome, although the literature reflects common assumptions about their effects. Consultants have identified consultee characteristics as contributing more to consultation success or failure than any other factor (Martin and Curtis 1981). Since the consultee is an integral part of the consultation triad, consultee characteristics interact with those of the other members of the triad with varying impact on the consultation process.

Demographic and cultural variables are the consultee characteristics that appear to influence the consultation process most. It is the conventional wisdom of this young field that demographic and cultural differences between the consultant and the consultee complicate the consultation process and contribute to its failure (O'Neill and Trickett 1982; Westermeyer and Hausman 1974a). However, Larsen and Norris (1977) found that the degree of similarity between the consultant and agency staff on the demographics of age, sex, ethnic group, professional background, and geographic location was unrelated to consultation outcome--a finding replicated in their larger, more recent study (Larsen and Norris 1982). In interpreting these findings, it should be noted that they are based on program consultation in which consultees were usually members of the administrative staff. Differences in demographics and culture between the consultee and the client may also create problems. Westermeyer and Hausman (1974a), in considering the combinations of ethnicities possible in the consultation triad, suggest that problems multiply geometrically as these differences increase. They identify the most problematic situation as one in which the consultant, client, and consultee all have different backgrounds.

Such situations are likely to increase over the next decades since members of minority groups are not proportionately represented in the ranks of mental health professionals in training. Barrera (1982) notes the lack of sufficient Hispanic mental health professionals and the unlikelihood that the situation will improve in the foreseeable future. He concludes that alternative approaches to Raza mental health--focusing on system change--are necessary.

Characteristics of the consultee organization are major contributors to consultation outcomes for interventions at the administrative and organizational levels: "The single most critical determinant of consultation outcome may be agency attitudes and expectations" (Larsen and Norris 1977). Consultee characteristics that have been identified in the literature as relevant include the organization's past success with consultation and organizational renewal; its need for, receptivity to, and preparation for consultation; and its internal communication patterns and decision-making processes.

The most comprehensive study of the relationship between the characteristics of consultee organizations and consultation outcome utilized a national sample of community mental health centers (Larsen 1982, Larsen and Norris 1982). The centers were invited to participate by requesting free mental health consultation on a topic of their choice. Using a control group design, responding centers were then asked to identify the problem that led to their request. The major outcome measure was extent of problem solution. Results showed that centers receiving consultation reported significantly higher levels of problem solution 8 months following the intervention than centers not receiving consultation.

Four characteristics of the consultee organization were investigated in the study: demographic variables, perceived need for program change, and factors internal and external to the setting. The demographic variables studied were defined as region of the country, metropolitan status, budget, number of full- and part-time employees, tenure of the director, and age of the center. None of these variables were found to be significantly related to consultation outcome.

The limited duration (1 or 2 days) of consultation in this study may have been too brief to overcome threshold effects. This seems particularly likely in considering the significant relationship found between perceived need for program change and consultation outcome. Four months after the experimental intervention there was a negative correlation between perceived need and degree of problem solution. The authors suggest that organizations with perceptions of high needs for program change may have problems too severe to be affected by a brief consultation.

The internal characteristics of the consultee agencies studied covered the two broad categories of organizational structure and attitudes. Four structural characteristics were selected for study: openness of communication, staff involvement in decisionmaking,

participative problem solution, and past success with organizational renewal. None of the four were found to be significantly related to consultation outcome.

Of the four characteristics of organizational attitude investigated, two were significantly related to outcome: administrative sanction for consultation and experience in using consultants. However, the consultee agency's past success with consultation was not related to consultation outcome in this study, nor was staff preparation for consultation. This is in conflict with the more frequently held view that these variables influence consultation success (Bloom 1975; Carner 1982). The Larsen results appear to be a function of the way in which these variables were defined and measured. Larsen and Norris suggest that "the measures of organizational factors were too broad and too general to assess degree of problem solution in one specific program" (1982, pp. 148-149).

Characteristics external to the setting were also found to be significantly related to consultation outcome. The eight external characteristics studied were legislation, local governmental policies, support from the community governing board, community attitudes, local economic conditions, changes occurring in other community mental health centers, attitudes of referring agencies, and client needs. Those centers scoring higher on this scale--i.e., those in which legislation and policy facilitated change, and the community was supportive--also achieved significantly more problem solutions.

Clients

The client is the pivotal member of the consultation triad. The client's needs create the consultation contract, define consultation content, and shape--directly or indirectly--the assessment of consultation impact. Historically, mental health consultation was a dyad, pairing the consultant and the client in a direct service encounter, usually of a clinical nature, from which the consultee was excluded. While the model has since expanded to the current triad in which the consultee is an active participant, the client's well-being continues to drive the model. Two major client-related consultation issues are the identification of the client and the impact of client characteristics on the distribution of consultation services.

Identification of the Client

The question of who commands the consultant's primary allegiance is a difficult one. According to O'Neill and Trickett, "There is almost always ambiguity about who is the real 'client' of consultation . . ." (1982, p. 21). In theory the client who pays is seen as the one whose interests are served by the consultant. In practice this principle is sometimes difficult to honor.

When the consultant is being paid, it might seem obvious that whoever pays the piper calls the tune. This is true to the extent that consultants who ignore the wishes of those who sign the check often (but not always) have their contracts revoked. Nevertheless, consultants frequently use formal sponsors to provide them with the means to work with those they consider their real clients (O'Neill and Trickett 1982, p. 78).

The problem of identifying the client is often an issue in situations in which the targeted person is at some disadvantage in the setting (i.e., prisoners, minorities, the poor). The disadvantage may be a function of the person (i.e., felons), the community (i.e., prejudice), or a mix of the two. The thorniest dilemmas for the consultant are cases in which the client's disadvantaged status is a function of discriminatory societal practices. Focusing remedial efforts on the victim leaves the system that produces victims untouched. Since the victims in these cases are generally powerless, the resources available to pay consultants to "fix" them come from the offending society itself. The consultant is caught in the paradoxical situation of being paid by an abusing society to ameliorate the consequences of abuse. Consultants who challenge the system risk the loss of project funds (Berlew and LeClere 1974). On the other hand, those who accept society's funds to treat its victims may contribute more to maintaining the system than to helping its victims (Grady 1978).

Impact of Client Characteristics on Distribution of Services

The distribution of mental health services across client populations is systematically skewed (Report of the President's Commission on Mental Health 1978; Snowden 1982). Minorities, the elderly, infants and small children, the chronically mentally ill and their families, and residents of rural areas are all underserved by the mental health system in this country. Two reference guides, covering the publication periods of 1968-1972 (Mannino and Robinson 1975) and 1973-1978 (Grady et al. 1981), reviewed a combined total of 2,020 publications on mental health consultation. In preparing this chapter, Swift determined that 1,164 of

these 2,020 entries specified consultation settings and categorized those 1,164 into 13 different consultation settings. Table 1 documents the distribution of publications of mental health consultation activities across these settings and confirms the lack of consultation resources channeled to underserved populations.

Table 1. Number and percentage of mental health consultation publications by consultation setting, 1968-1978

| Consultation Setting | Number of publications by mental health settings | Percentage of setting-related publications |
|--------------------------|--|--|
| | | N=1,164 |
| Cross-cultural | 85 | 7.3 |
| Educational | | |
| Preschool | 57 | 4.9 |
| Elementary and secondary | 447 | 38.4 |
| High school and college | 46 | 4.0 |
| Geriatric | 15 | 1.3 |
| Government | 13 | 1.1 |
| Hospitals | 223 | 19.2 |
| Industrial and business | 52 | 4.5 |
| Law enforcement | 70 | 6.0 |
| Military | 27 | 2.3 |
| Minority | 27 | 2.3 |
| Religious | 27 | 2.3 |
| Social agencies | 75 | 6.4 |
| Total | 1,164 | 100 |

Sources: Grady et al. 1981; Mannino and Robinson 1975.

In reviewing these data, some caveats should be observed. While the universes of practice and publication are not identical, they overlap. It is likely that these data sample proportionately more mental health consultation activities conducted by students and staffs of universities than those conducted by staffs of community mental health centers. The mandate to "publish or perish" reinforces academics to share their work with the field through publication. The incentives for center staff place little emphasis on publication. A review of service delivery by settings underestimates the distribution of services to populations that are primarily

served by specific settings since members of these populations may receive services in multiple settings--i.e., the elderly are likely to receive services in hospitals as well as in geriatric settings.

With these caveats in mind, a review of the proportion of publications focusing on settings can still be instructive in indicating the priorities of the field. Where settings listed can be identified as serving a specific population, it was found that only 1.3 percent of the publications relate to geriatric settings, 4.9 percent relate to preschool settings, and 2.3 percent to minority settings. Thus, less than 10 percent of professional mental health consultation activity, as reflected in this publication review, was directed to these three underserved groups across the 10-year publication period.

As might be expected, the traditional educational and health settings show the most setting-related publications. Although educational settings account for almost half of all the setting-related publications, only a tenth of these publications relate to children younger than school age. The overwhelming majority of mental health consultation in educational settings, as reflected in the literature review, takes place in elementary and secondary school settings.

Data gathered by the National Institute of Mental Health (NIMH) from Federally funded community mental health centers (CMHCs) provide another estimate of the distribution of mental health consultation services to broad populations and settings (Goldstein 1977; Hassler 1981). In 1978--the last year for which data are available--less than 7 percent of all CMHC staff hours devoted to consultation and education activity was spent delivering services to the elderly. While children are shown to be the largest single recipient group, the bulk (75 percent) of consultation is with the elementary and secondary school levels. Similarly, Goldstein (1977) reports that rural centers receive the lowest amount of consultation and education of the three locales--metropolitan, mixed, and rural--irrespective of the income of the rural catchment area.

In summary, then, estimates from two sources sampling distinct but overlapping universes confirm that the elderly, small children, and rural areas are underserved by mental health consultation services. Available evidence also confirms the neglect of minority populations by the formal mental health system. Snowden (1982) provides a comprehensive review of populations underserved by this country's mental health system.

We have reviewed evidence indicating that the client demographics of age, minority status, and rural residence are associated with disproportionately low shares of mental health consultation resources. However, there is no systematic evidence to indicate that these resources are distributed disproportionately by client gender across settings. Mental health consultation resources appear to be distributed according to the gender patterns characteristic of the setting. Differential allocation of consultation resources by gender within settings may reflect demographic realities, discriminatory service distribution or utilization patterns, or both. For example, consultation in military settings serves more males than females, whereas the situation is reversed in geriatric settings. While the distribution of consultation services generally reflects the setting's established gender patterns, a sudden shift in gender balance may trigger consultation programs addressing the shift and its consequences--as, for example, when females are introduced into traditionally male settings such as military academies and police departments.

Summary

This chapter has focused on the environment in which mental health consultation occurs. Three critical components of the consultation environment have been discussed: settings, consultees, and clients. Setting variables that the consultant must take into account include the consultee agency's mission, values, and lifestyles, its administrative structure and processes, and its characteristic temporal sequences. While consultation issues and trends were outlined for 11 settings, 2 traditional mental health consultation settings--educational settings and hospitals and other health settings--continue to dominate the field, as reflected in publications and service delivery data.

The evolution of mental health consultation theory and practice has gained impetus from a major shift in consultation goals over the last decade. The classic mental health consultation paradigm--case consultation in the service of treatment goals--is being challenged on both ideological and economic grounds. While the case consultation model still appears to command major resources in the field, the goal of prevention has captured the attention and allegiance of increasing numbers of consultants. Prevention strategies dictate that the target for change be broadened to systems as well as individuals. This development has led to an expansion of levels of intervention beyond the consultee agency to encompass the larger community and the social system within which the consultee agency functions. Two clear future trends are the continued proliferation of consultation settings and the

emergence of social system change as a major consultation strategy.

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CHAPTER 14

ETHICAL AND PROFESSIONAL ISSUES IN MENTAL HEALTH CONSULTATION

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Mental health consultation is a relatively new and expanding area of professional practice. It involves complex interventions at individual, organizational, and community levels. The combination of complex system interventions and nontraditional professional roles means that ethical issues are very important to the field at this time. There is a need to make explicit the types of ethical and professional responsibilities that are assumed in the provision of consultation services, and to articulate useful ways in which to consider the ethical problems that are encountered.

There are a number of important and interrelated reasons for undertaking such a task. First, norms and standards of practice for mental health consultation need to be specified in order to establish a common basis within the profession and the society for judging what is acceptable professional conduct. Given the complexity of the consulting process and the many contexts in which it occurs, it has proven very difficult to define a code of ethics in the field of consultation (Gallessich 1982). Continued efforts are needed to establish frameworks in which ethical conflicts can be identified and resolved, and to develop, as Benne (1959) suggests, general "advices" regarding ethical problems.

Second, as Golann (1969) writes, ethical dilemmas often arise out of situations that involve multiple loyalties and conflicting demands and values. These characteristics are the rule and not the exception in consultative practice. For consultants to resolve issues of competition between individual and social needs, and among conflicting interests and values (including their own), requires that serious attention be given to professional responsibilities and ethical principles.

Third, the fact that consultative intervention involves issues of power, influence, and change (at both individual and social levels) means again that consideration of ethical issues takes on particular significance. The power and status assigned to the social role of consultant creates the opportunity to effect constructive and meaningful change. At the same time, the consultant's power and privilege can be misused (Gallessich 1982), and

can result in threats to individual freedom (McNeil et al. 1970). Kelman (1965) underscores the responsibility on the part of the social scientist regarding how knowledge is utilized, especially given the increased availability of knowledge about the control of human behavior and the readiness in society to utilize such information. All of these factors create a basis of concern about ethical problems.

Ethical standards grow out of the shared experiences of those involved in an area of professional practice. They encompass a set of moral principles and values that are to guide the actions of group members. While a focus on technical issues in consultation is concerned with the development of effective methods of practice, attention to ethical issues involves an assessment of the likely impact of the interventionist's actions on the interests of all those affected, directly or indirectly, by the intervention (Katoff 1979). Determining whether something ought to be done, how it ought to be done, and who it ought to involve includes both technical and ethical considerations which are highly interrelated and which together shape the conduct of the work. The consultation field is evolving both technically and ethically in an effort to refine intervention methods and to articulate related principles of ethical conduct.

This chapter is an attempt to further the considerations of ethical issues in mental health consultation and to suggest that this can best be accomplished by taking into account the situational factors that continuously impinge on the work. Therefore, we will first present a conceptual framework within which key ethical and professional issues will be discussed. The focus will be on the conceptualization of the consultant-consultee relationship as it exists within an organizational, interorganizational, and community context. This contextualized view helps to frame ethical questions in a different way. We will take the position that ethical issues and problems pertaining to the consultant-consultee relationship cannot be adequately understood in isolation from the relationships, conditions, and events in the surrounding organizational context.

We then will examine a number of central areas of ethical responsibility and will explore typical ethical dilemmas that arise in the provision of mental health consultation. Five areas will be covered: (1) the consultation agreement, (2) values conflict and clarity, (3) confidentiality, (4) competence and resources, and (5) outcomes of consultation. In each case, we will first define the key ethical issue and then summarize the basic thinking in the field, paying particular attention to those situations or conditions that lead to ethical dilemmas in the consultant-consultee relationship. The attention of the field, as reflected in the literature,

has been devoted primarily to these five areas of ethical consideration. An additional reason for selecting these areas for discussion is that they are particularly illustrative of how ethical dilemmas arise out of the complexity of the consultative process and of the embeddedness of this process in complex social structures. The final section of the chapter will be devoted to a discussion of professional standards in relation to the ethics of consultation.

Conceptual Framework

One way to discuss the ethics of consultation behavior is to focus on the application of codified norms to the working relationship between two individuals: the consultant and the consultee. The agreement or contract between these parties can be examined as to whether or not each side has fulfilled its obligations in areas that are seen as having either moral (e.g., values) or protocol (e.g., confidentiality or professional conduct) components. The consideration of ethical behavior and standards, therefore, is focused on the appropriateness of, and degree of compliance with, the one-to-one agreement between consultant and consultee.

Given the "systems approach" that in some way underlies most techniques of consultation, this view of ethics seems too narrowly focused. The attention of most human service fields is on context; the interpersonal, organizational, community, and societal environment of behavior (Kelly 1966). This ecological approach is particularly appropriate when considering ethical issues in mental health consultation. Consultation, by definition, is an effort to use the consultant-consultee relationship to create change in the surrounding organizational environment. Both the consultant and consultee act not only as individuals with their own idiosyncratic set of values and agenda, but also as members and representatives of their respective organizations. These organizations also exist in a network of interorganizational links, often including a nested hierarchy of "parent" organizations for both the consultant and consultee, as well as other systems which have important relationships with both parties. The particular nature of consultation, with its focus on system change rather than individual cure, means that attention to organizational surroundings is critically important. In developing ethical norms and in assessing compliance with ethical standards, the consideration of these contexts is essential; without it the consultation contract and the conduct of the consultative interventions cannot be meaningfully evaluated.

The discussion of context in mental health consultation may have begun, like many other discussions, with the work of Caplan (1970). By expanding the field of attention from the provider-recipient dyad to the consultant-consultee-client triad, he initiated the examination of the alternative roles available to the mental health professional. Although he included program-focused models, his view was still fundamentally circumscribed within this triadic focus. Other writers have furthered the expansion by discussing the impact of such contexts as the organizational employer of the consultant (Shore and Golann 1969; Wand 1981), the professions (Bakalinsky 1980; Benne 1959), and the community at large (Davis and Sandoval 1982; Fanibanda 1976; Northman 1977).

Following from these conceptualizations, commentary and research on ethical issues in mental health consultation should be reviewed in terms of their relevance to "real world" contexts. Discussions that make use of an ecological perspective, considering the exchange between consultant and consultee in its political, economic, and organizational contexts, will contribute most fully to an understanding of ethical dilemmas in consultation. Some of the issues that might emerge from this perspective include the following:

1. Characteristics of the consultant

- What are the personal values and characteristics of the consultant which are relevant to the task of the consultation?
- What are the rewards sought by the consultant: money, access, status, influence, satisfaction?
- How is the individual consultant located in the consultant system--i.e., with what degree of authority and freedom to carry out the tasks of the consultation?
- What is the relationship of this consultation to other work of the consultant system?

2. Characteristics of the consultee

- What are the personal values and characteristics of the consultee which are relevant to the task of the consultation?

- What are the rewards sought by the consultee: knowledge, power, status, release from responsibility, satisfaction?
 - How is the individual consultee located in the consultee system, with what degree of authority and freedom to authorize the consultation, give the consultant access, and commit the consultee system to serious consideration of change?
 - What is the relationship of this consultation to the overall work of the consultee system, and what would be the impact of change in the consultee on the consultee's surroundings in that system?
3. Characteristics of the relationship between consultant and consultee systems
- What is the history of the relationship between the consultant and the consultee?
 - What is the history of the relationship between the consultant's system or organization and the consultee's organization?
 - Do the two systems work together in other ways?
 - Are key individuals in the two systems connected socially or by participation in other joint ventures?
 - What would be the impact of events in either system on the conduct of the consultation?
4. Characteristics of the consultant and consultee systems' relationships to the community
- Do both systems serve the same community?
 - What is the relationship of the consultant system to other providers of service to this consultee?
 - What is the relationship of the consultee system to other clients of the consultant?
 - Do the two systems have in common any policy boards, funding sources, or oversight groups?

- What meaning will the linking of the consultant and consultee organizations have to other systems in the network or the community?

Applying this perspective to the question of ethics, the consultant and consultee can both become more aware of the influences that may have an impact on the consultative relationship (Eilbert and Eilbert 1982). Both parties can then address the ethical components of such questions as what limitations need to be set on the areas of work; what additional authorization is necessary before beginning; what particular individuals in either system should be included in, or excluded from, the process; what special issues need to be considered in resolving potential ethical dilemmas in the work (such as value conflict, confidentiality, or responsibility for outcomes); and, in some cases, whether ethical complications suggest that the work should not take place, or should be terminated in progress. Clearly, attention to context serves to inform both the technical and ethical components of consultative intervention. The consultant-consultee relationship simply does not exist in isolation from the wider social environment. It is this perspective that will be applied in an effort to more fully articulate the five areas of ethical responsibility that will be discussed in the following section.

Typical Ethical Dilemmas

Ethical Dilemmas Arising From the Nature of the Consultation Agreement

The provision of consultation services occurs on the basis of some agreement or contract, either explicit or implicit. This agreement must include at least an indication of who the parties are, what the work is about, and what the benefits are that will be gained by each side as a result of the work. The consultation literature deals only briefly with contractual issues, primarily in recommending attention to "pre-entry" issues as fully as possible at the time of negotiating the consultation (Cherniss 1976; Fanibanda 1976). Other important areas of ethical consideration which have implications for the contract, including protection of confidentiality and responsibility for the outcomes of the consultation, will be discussed in later sections of this paper. However, one additional issue which is touched on in many articles in philosophical terms, but rarely explored in any detail, is the specific identities of the consultant and the consultee. This issue is of particular relevance in attempting to clarify to whom the consultant is primarily responsible and how the consultant will

respond to conflicting agenda within the consultee and consultant organizations.

In keeping with the conceptual framework of this chapter, the contract can be seen not only as a description of specific obligations of two parties toward each other, but also as a representation of the agenda of a range of sponsoring organizational levels. In a contract prepared by a consultation agency, the letterhead on which the contract is typed may represent a corporate or departmental level which is primarily interested in obtaining and keeping the work, whatever its content. The consultant whose efforts are described in the contract may be more concerned with the level of realism in the expectations held for the work, and the level of resources the consultant will have to call upon. The members of the consultee organization who are described as the primary recipients may be most interested in how they will be asked to change and how fully they will be protected during their participation. The administrator who signs the contract for the consultee organization may be concerned with cost, exposure, and whether or not the consultation can effectively make changes that the administration has been unable to accomplish on its own. As a result of the complexity of the organizational contexts of both the consultant and the consultee, some ambiguity can arise about the mutual responsibility of the parties in the consultation agreement.

As Lippitt (1961) and Shore and Golann (1969) point out, in any organizational setting there will be internal conflict and competing agenda (also Bowen 1977). Specifying the consultant's various obligations to different individuals or subgroups within the consultee organization can be difficult, particularly since the professional/bureaucratic nature of many human service organizations means that the consultant's initial contact with a potential consultee could occur at a variety of different locations in the organization. The consultant could be primarily responsible to those who negotiate for the work, or to those who will be the direct participants in the activities of the consultation. Similarly, primary responsibility could be to those who will be affected by the consultation, to those who will authorize or pay the fee, or even to those who have the ultimate senior authority over the organization. Complications arise because these functions are typically not filled by the same sectors in a consultee organization. Some sectors may seek organizational change, and others may resist it. As a result, ethical as well as technical issues arise, because consultants make decisions and form alliances early in the work which support some agendas and threaten others (Baizerman and Hall 1977). To the extent that there is ambiguity within the consultee organization about the individuals to whom the consultant is primarily responsible, the members of that

organization may not have the information they need to make informed choices about how they want to participate in the work while protecting their own legitimate interests.

A particularly common dilemma occurs when one sector (usually senior management) wants to arrange consultation for another sector. The consultant may have difficulty sorting out such ethical concerns as whether or not participation by the consultee has been truly voluntary, whether or not the consultee is being used to bolster one side of an internal argument, and whether the consultee is free to maintain confidentiality within the consultee's own system.

The issue of fee can sometimes help clarify the identity of the primary consultee, but it can also further muddy the waters. In a recent case, one of the authors acted as a facilitator for a group of support and clerical staff in a large social service agency. The consultation had been authorized by top administration as one of a series of retreats for all staff--first administrators, then client care staff, and finally support staff. All negotiations were carried out with a committee of the support staff who represented themselves (in the presence of administration) as the fully authorized "consultees" for the project. After the event, when a request from a senior administrator for a direct report on the consultation was denied by the consultant on grounds of confidentiality, the administrator's response was, "What do you mean that your agreement was with the support staff? My name is on the check--you were working for me!" This issue of identifying the primary consultee can be of critical importance, particularly for mental health consultation provided by public sector consultants, where third-party support for consultation, from either distant levels within the consultee organization or from outside sources, is relatively common.

A second dilemma which is of particular importance to mental health consultants is the ambiguity between the consultant's responsibilities to the consultee organization and to the clients of that organization (Davis and Sandoval 1982; Fanibanda 1976; Gallessich 1982). Gallessich's "first principle" takes a straightforward contractual approach to the relationship: "Consultant's clients are the agencies that hire them" (p. 397). This approach seems closest to the intention of Caplan (e.g., 1970, p. 125). Fanibanda, on the other hand, argues that "the consultant has his primary responsibility to the society 'client system' and only secondarily to the consultee" (p. 549). Davis and Sandoval make the same argument, adding that obligations to the consultee, such as confidentiality, must be sacrificed when the consultant feels that client welfare is endangered.

There are limitations on both points of view. It is conceptually awkward to consider the clients of the consultee agency to be a part of the consultation agreement since they are not present, do not have an opportunity to articulate their own priorities, and most often do not even know that a consultation is taking place. On the other hand, regarding only the consultee organization would require a narrow definition of the role of the consultant as a mental health practitioner. Especially if the consultant is operating out of a prevention ideology, the consultation is seen as a means toward the ultimate objective of having an impact on the target population. In that sense, the client remains as the ultimate recipient of the consultation.

Ethical dilemmas arise when the potential interests of the consultee and client are in conflict. For example, Wand (1981) highlights the difficult situation of the school consultant who is caught between the individual needs of the child, the parents' agenda for maximum service, and the system's desire for control, consistency, and minimal cost. In a more general dilemma for case consultants, there is often conflict between the training agenda of a consultee agency and the rights of the clients to minimally intrusive interventions geared to their individual needs. The consultant who also acts as an advocate for a particular client group may face additional dilemmas. What are the ethical obligations of a specialist on mental retardation who is called in to help a beleaguered administrator of an underfunded mental retardation center write a grant, and discovers that the methods of care being used in the center are badly outdated? Are the obligations different if the care is not only mediocre, but truly incompetent? These kinds of conflicts can face an organization development consultant, as well. For example, should a consultant to a service organization recommend procedural changes that might make access to services more difficult for clients, but which would rationalize the design of the agency and reduce stress on staff? Or in industrial settings, what are the ethical issues facing a consultant who is asked by management to help the employees prepare for imminent layoffs, when the union claims layoffs are unnecessary and is encouraging their membership to resist rather than adapt? (Kurzman 1983).

Consultants are most interested in clarifying these issues of responsibility in relation to a variety of consultees. The complementary issue, clarifying who is the actual consultant, receives almost no attention in the ethics literature. On the consultant's side of the agreement as well, the tasks of negotiating work and carrying out work are not always accomplished by the same person or in service of the same values and goals. The "marketing" of consultation services may be determined by economic, political, and organizational considerations that compromise

confidentiality or assessment or that conflict with the intervention style of the individual consultant who eventually does the work. For example, a consultation agency may derive status from having ongoing contracts with certain consultees. This may subtly affect the individual consultant's judgment on terminating consultation or on referring a request for work to another consultant with more specialized skills.

The rights of the consultee as "consumer" also should be considered. If supervision or group planning are going to occur within the consultant agency during the consultation or after, does the consultee have the right to be aware of all members of that organization who will be privy to details of the consultation? To meet them? To veto participation by anyone the consultee doesn't like or trust? Is it acceptable for a consultation agency to negotiate for consultation work as an organization, and then assign whichever individual it feels is most appropriate (or has the time, or needs the experience) to actually do the work? On the other hand, does "buying" the consultation give consultees the right to specify a particular consultant, even if they might make a request based on a criterion (gender, race, age) that violates the values of the consultation agency? These issues require attention both in advance of the agreement process and as they emerge during the course of the work.

In summary, one of the important issues in consultation ethics involves the identification of the consultant and consultee and the specification of their obligations in the consultation agreement. Ethical dilemmas may arise from the conflicting agenda of multiple levels in the consultee organization and from ambiguity within the consultant organization concerning the autonomy of the staff consultant. Sensitivity to these complexities and early specification of details, as always, are aids in reducing ethical conflict. However, as Benne (1959) points out, there is a dynamic relationship between the consultant and consultee systems which does not permit anticipation of all areas of conflict which will arise in the course of the work. Negotiating the competing interests of subgroups within the consultee system is one of the difficult tasks of consultative interventions; it is only made easier if some clarity on the identity of the primary consultee is reached at the beginning of the work, as well as how work with this consultee will proceed in relation to others in the consultee organization. In addition, one of the consultant's contributions can be to help illuminate the areas of shared goals. As Kurzman (1983) recommends for consultation work in industrial settings, the best course includes (1) open discussion of dilemmas with the consultees as they arise, (2) reliance on professional ethical standards as the bottom line in ambiguous situations, and (3) an attempt to find metavalues that consultant, consultee

(management), and employee can agree on. "The professional challenge is to recognize the symbiotic relationship and discover the equilibrium that optimizes the common interest of both parties" (1983, p. 108).

Ethical Dilemmas Arising From Values

Values are the comparative worth that we ascribe to things—in this case, to outcomes or alternatives. They are related to ethics because a value hierarchy can provide one criterion for resolving conflict about acceptable behavior. A mental health consultant, like any professional service provider, is continually faced with alternative, and mutually exclusive, courses of action in attempting to facilitate change. The decisions made by that individual about ethical methods and goals, as well as the collective "decisions" that are represented by ethics codes, are manifestations of values about what outcomes are more important than others, what risks are reasonable, and what consequences are acceptable.

However, there is rarely a high level of consensus about values. Even within the individual, value conflicts can occur, especially when the individual is faced with the reality of consultative situations requiring action. For the most part, the literature does not explore values in great depth. In the private sector literature, there is frequent discussion of the conflict between profit orientation and humanistic values in business ethics (e.g., Nash 1981). In the literature on mental health consultation, the discussions are typically very general and do not often consider the contextual perspective that underlies this review. When values are explicitly discussed, the issues which are raised usually fall into one of two categories: value-guided vs. value-independent technique and value-explicit vs. value-concealed process.

Value-guided vs. value-independent technique. In current writing, the extent to which values guide the work is most often presented as a continuum; no one argues (anymore) that consultants can be value-free completely (although Zaltman and Duncan found a "vehement" subgroup of practitioners who, in responding to a survey on ethical dilemmas, commented that they would never allow values to interfere with their consultation work [1977]). The most commonly raised questions concern the part that values should play in the consultant's choice of intervention techniques. The range of opinions about the optimal ethical use of values cluster into two different views of the consultant's role, which could be called the "choice increaser" and the "value advocate."

The "choice increasers" follow Kelman's argument that the role of the consultant inherently includes manipulation and therefore restricts the freedom of the consultee. This restriction is only justified in certain circumstances, primarily when the consultant works to increase the real choices available to the consultee (Benne 1959; Kelman 1965; Lewis 1972; Warwick and Kelman 1973). This is the closest anybody still comes to Weber's notion of the "value-free sociology" (Gouldner 1969). In this view, the consultants have values, but keep them from interfering in the process by being aware of them and by being vigilant that they do not restrict the options that the consultant presents to the consultee. This is the basic approach taken by Davis and Sandoval (1982) in one of the more thoughtful articles in the literature. They focus on the need for vigilant self-awareness in complicated contexts and offer some useful suggestions to the school consultant on traps to avoid. Their conclusion is that, in general, consultants are more likely to behave ethically if their overall view of consultation is (1) collaborative, (2) educational, (3) experimental (modifiable), (4) task oriented, and (5) protective of basic human rights.

Perlman (1977) also endorses "choice increasing" and self-awareness, but he is more concerned with community awareness. He argues that, in community settings, the professional arrogance of the consultant often gets in the way of encouraging active decisionmaking on the part of the community/consultee. He advises consultants to minimize their presentation as "experts," and to provide advice that is as "value-free and unbiased as possible. . . . When in doubt, keep your values to yourself" (pp. 52, 54; see also Fanibanda 1976).

The "value advocates" take a different stance; they claim that it is the obligation of the consultant to adopt a value orientation and work to implement it by actually reducing the number of options that appear acceptable to the consultee. In this case, the consultant seeks to minimize the conflict between what the consultee wants and what the consultant sees as overriding social good. Engleberg (1981), for example, argues that community psychology has already articulated values which regard "enhancing the quality of life for all members of a system" as more worthwhile than treating individual maladaptation. These relative values provide guidelines for determining ethical interventions. As another example, Mearig (1982) takes a basic value-advocate view of the responsibility of professionals toward children in need of services. In terms of our earlier discussion about specifying the primary consultee, she would unambivalently see the welfare of the clients as the consultant's overriding concern. She recommends the use of a sophisticated repertoire of clinical and systemic interventions, including political advocacy,

in support of the needs of children, even if some of those activities "go beyond traditional ethical guidelines" (p. 526) and place the consultant in apparent opposition to the practices of the service agency.¹

Values most often presented by "value advocates" as overriding include reducing sexism, racism, and other forms of discrimination in service delivery, humanistic approaches to education, and political empowerment. Most consultants would have no difficulty endorsing these concepts. The dilemma is over how central to make them to the conceptualization and implementation of an intervention strategy. In some cases, these objectives might be in opposition to the agenda of the consultee; more often, they will not be the focus of the consultee's attention. For example, a school system might want consultation on developing a truancy investigation team to tighten attendance enforcement in an alternative school, based on values that give a high priority to attendance (Gerber 1978). This creates one kind of dilemma for a "value-advocate" consultant who is committed to enhancing self-determination in adolescents, and another dilemma for a "choice increaser" who disagrees with the school system's approach but feels it was rationally arrived at in light of the system's view of education. Furthermore, there may be differences within the consultee organization about values. The superintendent may be concerned about "average daily attendance" reimbursement or may believe that all school programs need to hold to consistent standards of behavior, attendance, and minimal performance. The principal of the alternative high school may feel that the school program needs to be particularly responsive to the individual needs of students and therefore flexible in rule enforcement. A teacher may feel that the best learning environment requires the students to adjust to the realities of organizational demands. The consultant, with his or her own value hierarchy on individual adjustment vs. organizational integrity, must try to keep a clear sense of the role that all these value systems will play in the consultation.

Lippitt (1961) attempts to formulate a middle ground between value advocacy and choice increasing by differentiating between "methodological goals," such as good problem solving, and specific outcome goals. In effect, much like Bowen (1977), he suggests that consultants always need to be "value-advocates" for changes that maximize enhanced choice as broadly as possible in the consultee system. On the other hand, the particular form that new structures take, or the procedures that are implemented to increase personal freedom and choice, should be left to the consultee's discretion.

Another related issue is the "right to consultation": Are consultants, like lawyers, obligated to provide service to any consultee who enters the process in good faith and needs or would benefit from consultation? Or, on the other hand, are consultants free (or perhaps obligated) to refuse to work with consultees who represent values in conflict with the consultants'? Gallessich argues that consultants must choose; "consultants do not enter into contracts with an agency whose values are antithetical to theirs" (1982, p. 402). She acknowledges that this differs from the ethical codes of most other professions, but feels this is proper "because of the value-laden nature of organizational policies and actions--and their social consequences" (footnote, pp. 402-403). Fanibanda (1976), on the other hand, feels that consultants cannot just quit. "A consultant who knowingly withdraws his services because of a conflict of philosophies with the consultee is abdicating his responsibility to the society" (p. 549). The field is apparently divided; respondents to Zaltman and Duncan's survey were split almost evenly on whether or not consultants have an obligation to serve clients with different values (1977, p. 344). Bowen (1977) discusses both sides of the issue and cites an interesting view presented by Argyris (1970): If consultants refuse a priori to work with consultees whose values initially appear different, aren't they being "unwilling to question their own values and be open to change as they ask their clients to be?" (p. 550).

Value-explicit vs. value-concealed practice. Given the complexity of value systems for both the consultant and the consultee, it is inevitable that some degree of conflict, or at least lack of agreement, will occur (Hastings Center Report 1978). In keeping with the conceptual framework that underlies this chapter, potential incongruence in values should be considered not only between individual consultants and consultees (Benne 1959), but also between professional standards and organizations (Bakalinsky 1980), between providers and the client populations they serve (Shore and Golann 1969), among members of a consultation team (Bowen 1977), and within consultants themselves (Lewis 1972; Tichy 1974). Tichy's work is one of the only empirical studies in this literature investigating the degree of value-action and cognition-action congruity in change agents who use different intervention techniques. He found that organization development consultants demonstrated the lowest levels of value-action congruence (1974, p. 179).

The likelihood of some level of value discrepancy raises the issue of how explicit the consultant is obligated to be in uncovering and exploring values with a potential or current consultee. Do consultants have the responsibility to describe their values to potential consultees? (Tichy 1974; Zaltman and Duncan 1977).

What if the discrepant values do not appear to be directly relevant to the task at hand, or if they are apparently different but compatible? Is it the consultant's judgment, or should an "absolute disclosure" rule apply? Gallessich (1982) advocates full disclosure and discussion when discrepancies become obvious to the consultant, but she wisely points out that the timing of this awareness is not always clear. Even the most experienced and sensitive consultant may only come to observe value differences on such issues as supervision style, personnel policy, objectives for client care, or overall vision for the organization after engaging in the consultation for some time. Raising these issues well into a consultation will require even more skill and determination than doing so while considering whether or not to accept a consultation (Cherniss 1976).

As Gerber (1978) points out, the most practical questions are not about absolute agreement or conflict, but rather about what level of compatibility in values is required. Presumably the consultees must perceive some level of agreement, or they would not have sought out this particular consultant. Assuming that, if asked about their values, consultants should answer truthfully, what are a consultant's obligations if not asked? In the easiest case, is it all right to keep quiet about value differences that the consultant assumes or observes, but which do not interfere with the consultant providing the service asked for? In the harder case, is it all right for consultants to keep quiet about values that they are pursuing while carrying out the consultation--such as changing the way the system treats its female members by inviting them into roles in the consultation which enhance their status?

As Benne (1959) points out, for these issues it is difficult to distinguish between technical and ethical dilemmas--that is, between questions of good practice and questions of ethical practice. Perlman (1977) poses an interesting situation where a community has hired a consultant to assist in the establishment of a day-care center. The consultant, after careful diagnosis, estimates that by dealing as an "expert" and focusing on the specific task, he can help bring about a day-care center in 8 months. Alternatively, by consulting to the committee members on consensus building, methods of planning, fundraising, and community mobilization, the overall skill level and empowerment potential of the community will be raised, but the opening of the day-care center may be delayed several months. Perlman's conclusion is that the ethical consultant will share this dilemma with committee members and let them choose which course of action to take.

This solution is fine as far as it goes, but it seems to oversimplify this typical scenario in several areas. First, the consultant is rarely able to provide so clear a prediction of technique/

outcome choices ready for cost-benefit decisionmaking. Second, the community is most often made up of many interest groups with different or competing agendas, making a rational decision process on issues such as this a potentially long, divisive, and energy-draining task. Third, asking the consultant to "share his perceptions" and to be "open to whatever course of action is valued highest by community members" does not offer guidance on how the consultant can manage his or her own values as they affect in subtle ways the presentation of options, or whether or not the consultant has a right (or an obligation) to an opinion. Mailloux (1979) and Zaltman and Duncan (1977), for example, would argue that while the decision rests with the consultee, an ethical consultant may, or should, argue forcefully for the alternative that the consultant feels is best.

Overall, the literature is interested in two basic questions concerning values as related to ethical consultation practice: Should the consultant present alternatives in as value-neutral a manner as possible, relying on the consultee to make value judgments, or is the consultant permitted (or obligated) to take positions on alternatives based on personal values or an interpretation of professional standards? Second, when do consultants need to describe their values to consultees--during the earliest phases of negotiation for projects, at the point when a discrepancy appears likely to the consultant, if and when the consultant feels that a discrepancy may affect or is affecting the work, or never? Finding resolution to both of these questions will not simply be a matter between a given consultant and consultee. Their decisions regarding what is ethical behavior will occur within a field of multiple and competing values. This is an area of great complexity, with remarkable differences of opinion implicit in the literature.

Ethical Dilemmas Related to Confidentiality

The use and limits of confidentiality in the practice of consultation is a central ethical concern. Indeed, in a survey of ethical standards of special concern to organization development consultants (Glaser 1981), two issues that emerged were violation of confidences and invasion of privacy. Drawing first from the clinical context, Siegel (1979) defines confidentiality as "... an explicit promise or contract to reveal nothing about an individual except under conditions agreed to by the source or subject" (p. 251). Siegel's review of ethical considerations regarding confidentiality leads him to support the position that absolute confidentiality should be maintained in professional practice within the constraints established by law. Bok (1983) sees confidentiality as the boundaries surrounding shared secrets and

the process of maintaining these boundaries (although there are both positive and negative implications to guarding such "professional secrets"), while Pettifor (1980) asserts that the essential value in confidentiality is the right to individual privacy. Bok (1983) writes further that a central purpose in applying the principle of confidentiality is to protect information given in confidence from third parties, at least under certain circumstances. Four premises are outlined as a rationale for confidentiality. These are: "human autonomy regarding personal information, respect for relationships, respect for the bonds and promises that protect shared information, and the benefits of confidentiality to those in need of advice, sanctuary, and aid, and in turn society" (p. 25).

The basic principles contained in these definitions are certainly as applicable to consultation as they are to clinical practice. Moreover, given the nature of many consultative interventions, they are matters that often extend beyond a particular individual to groups within an organization or to the organization itself. These multilevel interactions can add layers of complexity to the issue of confidentiality. Some of the complexity encountered is unique to consultation, while certain of the issues are found in common with clinical and other types of professional practice. The discussion of confidentiality will focus on two areas: (1) third-party (and multi-party) situations and the types of considerations that must be given to how information is treated within the context of such situations; and (2) defining or establishing limits on confidentiality and on what basis, and in what situations, such limits might be considered.

Multi-party situations. It may be that there are at least three parties to any consultation, either directly or indirectly. In case consultation, there is the consultant, the consultee, and the consultee's client or clients. In program and administrative consultation, there is the consultant, the consultee or consultees and their relationships to each other, and the consultees' clients, peers, subordinates, and superiors. In a systemwide intervention, various individuals and groups with different patterns of relationships to each other will be involved in the consultation. The consultant's relationships to individuals within the consultant's own homebase organization and within the community potentially add other parties to the situation. Moreover, external organizations (funding sources, etc.) may have an interest in the conduct and outcome of the consultation and may want access to certain information or reports from the consultant.

Multi-party situations place constraints on confidentiality. In order to generate sufficient trust and openness for the work to proceed successfully, clarity must be reached regarding what

information will be shared, how it will be shared, and with whom it will be shared. A fair degree of consensus appears to exist in the field about how certain of these issues ought to be addressed. First, how confidentiality will be handled in any given consultation should be clearly outlined in the contract for services, and the release of any information where confidentiality has been guaranteed must involve informed consent (Davis and Sandoval 1982; Fanibanda 1976; Siegel 1979). Moreover, it is suggested (e.g., Gallessich 1982) that the consultant assist the administration of an organization to establish policies pertaining to confidentiality and to communicate these to all staff participating in a consultation. In this way, the development and promulgation of confidentiality policies are shared by the consultant and the consultee or consultee organization. Second, in considering what information might be shared and with whom, it is important to consider what the impact of that information might be and whose interests will be served by sharing it (Pettifor 1980). Third, confidentiality involves concerns for the consultee and client, and needs to be considered from both the consultant's and consultee's standpoints.

Most considerations from the consultee's standpoint have been about case consultation. In these situations, it is generally felt that the consultee should have the consent of the client prior to any discussion with the consultant (Fanibanda 1976). This approach still leaves room for the consultee to present cases anonymously for discussion with the consultant. How the principle of informed consent is applied in other forms of consultation is less clear. Do administrators need the consent of their staff to discuss staff relationship problems and staff performance difficulties with a consultant? Do program supervisors need the consent of their peers and others in the organization to discuss problems encountered in the middle management structure of the organization? One does not want to encumber the communication and generation of information necessary to a successful consultation, but issues of privacy and confidentiality clearly are involved in these situations.

Parallel considerations about confidentiality are present from the consultant's standpoint. In case consultation, there are the questions of what and how much information to share about a consultee's client. Davis and Sandoval (1982) offer the guideline that one never shares specific information received in a situation in which confidentiality has been assured, therefore indicating that any limits on confidentiality must be explicitly established with the full consent of the client. In case and other types of consultation, it is felt that the consultant should safeguard the consultee from other influencing personnel such as supervisors or colleagues (Fanibanda 1976), and that the consultant should avoid

involvement in multiple roles and relationships that might create conflicts of interest--for example, giving confidential information to a consultee's organizational superior (Gallessich 1982). Because a consultant can often be perceived as an evaluator, special concern is expressed about how evaluative information is treated. In general, the position is taken that no evaluative feedback about individuals should be given unless such evaluation is an explicit consultative objective (Davis and Sandoval 1982).

External to the consultee organization are questions of what information the consultant is justified in sharing about a consultee or consultee organization within the consultant's homebase organization. What information is it appropriate to discuss for review and administrative purposes? Are there some individuals within the organization who should not be privy to specific information about the consultation because of other work or social relationships with the consultee or members of the consultee organization? Is there some information that the consultant should not share with his organizational superiors because of existing multiple agenda and potential conflicts of interest between the consultant and consultee organizations? This area of inquiry has received little, if any, attention in the literature.

Finally, there is the issue of confidentiality in relation to organizations external to the consultant and consultee systems. While it may be quite straightforward that one does not share information about a consultation with other professionals or members of the general community, it is not uncommon for pressure to be placed on a consultant to reveal information of some sort about a consultee or consultee organization to an external review group or funding source. This is especially true if the funding source or board was instrumental in identifying the need for the consultation in the first place, may have insisted that the consultee organization obtain consultative assistance as a condition of continued funding, or may in fact be funding the consultation.

This type of situation is illustrative of the shared and competing agenda that are always present in multi-party arrangements. It continuously places pressure on the consultant and consultee to reveal information to others outside the consultative relationship, which may or may not be in the best interests of the work. The complexity of these situations places particular importance on developing clear understandings and contractual agreements regarding what information is confidential, who will discuss what information with whom, what are the limits of confidentiality and why, and how requests for information from within and outside the consultee and consultant organizations will be handled during the course of the consultation.

Limits on confidentiality. The question of limits on confidentiality has been discussed in two ways. The first has to do with the balance between the rights of the individual and the needs and well-being of society. Are there ever sufficient reasons to set aside the confidentiality established with an individual because of overriding concerns for others? There are obligations, for example, in clinical situations to report "clear and imminent danger" involving risk to self or risk to others due to disease or other danger (Bok 1983; Pettifor 1980). Is there a parallel in the field of consultation? Take, for example, a consultation to a residential child-care facility. Suppose the consultant finds evidence that staff members employ severely abusive disciplinary measures with the children, and that interventions to change such practices fail and discussions with facility administration and staff are unsuccessful. Does the consultant have an obligation to report these practices to the agency's board, funding source, or appropriate review body? There are serious implications to either reporting or not. If the consultant does not report, there is the risk of continued endangerment and harm to the children; if the consultant does choose to report, such action will impact on the consultant's reputation and may affect the level of trust that is possible to establish in other consultative relationships. When and for what reasons confidentiality must be set aside is not clearly established in consultative practice. Moreover, even in situations where concerns for the public good and for the well-being of innocent third parties are seen as overriding, limits would still need to be established regarding who is told what (Bok 1983).

The second focus regarding limits on confidentiality has to do with the distinction between anonymity and confidentiality. Information and communication are of central importance to the process and outcome of a consultative intervention. If information is restricted, especially in the diagnostic phase of an intervention, it may severely handicap the consultant's ability to provide necessary feedback, to facilitate discussions within the organization, and to plan change. Therefore, guaranteeing anonymity rather than confidentiality may be the better option in many cases. As Lippitt (1983) points out, the consultant needs to avoid the trap of possessing important data and not being able to use this data in problem solving, and does not want to support norms of secrecy that inhibit communication between subsystems of the organization. It is a matter of balance between protecting the individual on the one hand, and facilitating data gathering and communication on the other. In this way of thinking, one has several options: (1) facilitating open and more direct communication between parties so that the consultant is not the sole repository of information; (2) obtaining information with the understanding that it will be utilized in the consultation but that

the source of the information will remain anonymous; (3) identifying certain information or a particular problem or area of work that will be held in the strictest confidence within the consultant-consultee relationship. The ethical considerations regarding confidentiality obviously are quite different in each case and these variations need to be clearly understood between the consultant and consultee. What is most essential is that there be an explicit understanding of what boundaries regarding confidentiality have been set or given up, what information will be shared with whom and in what ways, and what the potential implications are of sharing such information outside of the consultant-consultee relationship.

Ethical Dilemmas Related to Competencies and Resources

The issue of consultants' capabilities and expertise in relation to a given consultation—including the accuracy of their self-perception and self-presentation of their competence and resources—contains a number of ethical considerations. Much depends on the consultant's self-assessment of competence, a sufficient understanding of the problem presented by the consultee, and a determination of the degree of fit between the consultant's particular capabilities and what is seen as required to be helpful to the consultee. All of these considerations will be influenced greatly by factors in the larger organizational context in which the consultant-consultee relationship is embedded. Obviously, this process is open to the possibility of distortion and misrepresentation.

Knowing one's limits. Two of the ethical standards of special concern to organization development (OD) consultants reported by Glaser (1981) included "failure to recognize one's own limitations of competence" and "failure to give the very best." Therefore, there are two sides to the issue of knowing one's limits: failure to recognize the lack of skills necessary to address the needs of a given consultation, and failure to provide the caliber of work that is within the consultant's limits of capability. It is extremely difficult to assess the contribution of these factors to the lack of effective progress in a consultation. Judgments about both depend on one being able to make comparisons against some established standards of professional competence. Such standards clearly do not exist currently in the consultation field. The central issue for individual consultants, therefore, is to establish some basis for judging the adequacy of their skills, training, and experience to meet the requirements of a particular consultative task, and in any given situation, to know the boundaries of their competence. Consultants that are beyond their areas of expertise should be aware of resources to supplement, or substitute for,

their own practice, and should, as required, refer to a professional who has the necessary expertise (Davis and Sandoval 1982). Training and experience obviously have a direct bearing on the issue of competence. Gallessich (1982) asserts that the consultant has an ongoing responsibility to stay abreast of new knowledge, to continually assess strengths and weaknesses, and to take active steps to upgrade skills and to maintain and increase effectiveness.

The question of resources for giving the kind of help needed in a consultation has been discussed by Lippitt (1961). An accurate estimate of the time and skill required to establish a consultative relationship is often unclear. Lippitt indicates that the amount of time and the range of skills needed frequently exceed what the consultant can bring to the situation. Especially in working with a group or organization, various types of special skills can be essential to promote the group's or organization's change efforts. If these are not recognized and anticipated, consultants will limit their effectiveness and possibly create new difficulties for the consultee. An example given is one in which the consultant offers diagnostic assistance and makes a number of recommendations for improvement, but provides no continuity from the diagnostic phase to the phase of change implementation. Such a situation is seen as potentially leading to disruption and demoralization if the consultee is unable to deal with the change process without further technical help. Lippitt suggests the consultant team model as a possible solution to this problem. Whether this approach is taken or not, attention to resources clearly is not merely a technical issue. It also involves considerations of the consultee's welfare and of obligations to provide services to the extent of the consultant's capabilities, and if these are not sufficient, to bring other resources to bear on the situation or to recommend where these might be obtained.

The process in which determinations must be made by consultants regarding level of competence and adequacy of resources contains a number of potentially contaminating influences. Even when issues of knowledge, skills, and prior experience are in question, there are a variety of pressures, from the consultants themselves or from the wider organizational context, to obtain and continue consultation work. These pressures come from many sources. Some may have to do with needed income or funding, or the desirability of certain consultative contracts because of the professional connections and visibility they would provide and the degree of status in the service network that could be attained by the consultant or the consultant's homebase organization. Others may involve influences from an outside funding source (public or private) to do a particular consultation and the need of the consultant or consultant organization to consider the implications for future funding opportunities if the work is refused. While honesty

and accurate assessment of skills and resources are called for from an ethical standpoint, the types of pressure mentioned above create a situation open to potential distortion. Clearly, the context in which the consultant works, and the consultant's own motivations, will make it difficult to turn down or reshape work that is very attractive or otherwise compelling. This then is the heart of the ethical dilemma faced by the consultant.

The issue of misrepresentation. The possibility of conscious or unwitting misrepresentation and of misperception and distortion due to individual biases is ever present in consultation practice. As noted above, the difficult judgments that have to be made regarding competence and resources, the complexity of accurately assessing the needs of a consultee or consultee organization, and the various extraneous pressures that surround the consultant and consultee and will influence their decisions about entering a service contract, all combine to create a situation open to potential misrepresentation.

Fanibanda (1976) asserts that the motivation of consultants offering services is always in question, but he also takes the position that consultants should present their primary intentions for offering consultation as clearly and honestly as possible. London and Bray (1980) argue that consultants have a responsibility to explain to potential consultees the limits of their technology and skill. Gallessich (1982) takes a similar stance in stating that consultants should present their knowledge, professional qualifications, and limitations accurately to avoid misrepresentation. She goes further, however, to address an additional way in which misrepresentation can occur, i.e., that consultants should avoid distorting an organization's problems to fit their own particular areas of expertise.

The latter point relates to the issue of consultant bias. How do consultants' values, beliefs, and ways of viewing problems influence their perceptions and determinations of an organization's needs and what they can bring to that situation? The influences are often very subtle, making it difficult to assess a consultant's actions from an ethical standpoint. Here as with other ethical quandaries, consultants, as Benne (1959) writes, must recognize, articulate, and resolve ethical conflicts for themselves. This requires a high degree of self-awareness. But as Gallessich (1982) emphasizes, consultants need to be aware of personal characteristics that might predispose them to systematic distortions, and change efforts and recommendations need to be based on objective assessment of the organization's problems and needs, and not be determined by professional biases.

Ethical Dilemmas Related to Responsibility for the Outcomes of Consultation

Where does the responsibility of the consultant end? What are the nature and extent of obligations that the consultant has to the consultee, the consultee organization, and the larger client system regarding the impact of the consultative intervention? Keeping in mind the embeddedness of consultation in a broad social context, consideration of such questions clearly requires attention to multiple agenda and interests arising from various sectors of the organization. Furthermore, consideration must be given to the fact that the consultant's and consultee's actions have the potential of impacting, directly or indirectly, on numerous individuals and groups. Questions concerning the consultant's responsibility for outcomes of consultation are complex, and various perspectives have been offered from a number of vantage points, not always with complete agreement.

Entry phase and contract considerations. The issue of responsibility for outcomes is not only relevant to later phases of an intervention (when recommendations are made or changes implemented), but also requires consideration at the time of entry and contract negotiations. As one part of the definition of the consultation, it is important to maximize clarity about the purpose and scope of the work, who will be involved directly in the consultation, and who is likely to be affected by the intervention. As Zaltman and Duncan (1977) indicate, the change agent needs to be aware of all parties within and outside of the target system who might be affected significantly by any proposed change. Similarly, in a discussion of applied social science, Kelman (1965) writes that social scientists must try to decide whether their work is likely to lead to more good than harm. Several questions become particularly relevant: How is the organization to use the findings of a study or diagnosis? Whose behavior will they attempt to change? What are the probable uses of findings in the short run and in the long run? Raising and attempting to answer such questions allows consultants to make more informed decisions early about what role they might play, if any, in a given situation given their understanding of intended outcomes.

Matters of contract then become important to clarify the role that the consultant will assume (Davis and Sandoval 1982), to set clear boundaries and definition for the work (what it will include and what it won't), and to deal as specifically as possible with issues of responsibility (Fanibanda 1976), especially what work the consultant is obligated to perform and at what point in the process the intervention will be terminated. In general, unless the consultee violates a contract in some way, the consultant is

professionally and ethically responsible to fulfill a contract and to remain within contractual boundaries.

Responsibility regarding negative actions of consultee. Once a consultation is underway, it may become quite difficult to distinguish between a specific outcome of the consultation and an action on the part of the consultee that would have occurred regardless of whether the consultation had taken place. Nevertheless, the consultant is faced with the question of what response to make to negative consultee behavior and actions. The general opinion, as discussed in earlier sections of this chapter, is that the consultant has a responsibility to consider certain steps in relation to the consultee and larger client system if the consultee's actions are viewed as unethical, inappropriate, or potentially harmful.

Among the ethical concerns of special concern to OD consultants reported by Glaser (1981) was failure to inform the client (i.e., consultee) if "an action is perceived as wrong, destructive or counterproductive" (p. 14). Bowen (1977) states that interventionists have many opportunities to influence the direction of changes that are implemented, and that "they have both the opportunity and the obligation to intervene in any situation where a client threatens to make unwarranted use of the data and knowledge produced in the consultancy" (p. 554). Going beyond simply giving feedback to the consultee, Bowen asserts that the consultant can, and should, inform other members of the client system whose interests might be adversely affected by the decisions or behavior of the consultee. Similarly, Lippitt (1983) poses a situation in which the consultant determines that a client's (consultee's) course of action will be harmful to others, but the client refuses to reconsider goals and behavior. In this type of situation, Lippitt suggests that "the consultant must consider informing the client of a decision to terminate the helping relationship, must accept a responsibility to a larger client system, and must consider sharing observations of the danger with those who might be harmed" (p. 149). Gallessich (1982) also takes the position that the consultant has an obligation to point out to the consultee any behavior that is viewed as unethical or potentially detrimental. However, she does not indicate that the consultant should take steps in relation to the larger client system and, in fact, suggests that if the matter cannot be resolved satisfactorily with the consultee, the consultant should consider discontinuation of services. In her view, the consultant is not responsible for the consultee's behavior.

The issue of withdrawal of services is a complex one. Fanibanda (1976), as indicated earlier, insists that the primary responsibility of the consultant is to the client system and only

secondarily to the consultee. In his formulation, the withdrawal of services may result in contributing to the maintenance of the status quo in the client system. Argyris (1970) has taken a particularly strong stance in maintaining that the consultant should not refuse services and should provide assistance unless doing so would compromise the consultant's values.

A quite consistent view in the literature is that the consultant has an ethical responsibility to point out to the consultee actions or behaviors that are seen as unethical or potentially detrimental. Beyond this point, the matter quickly becomes more complicated. Whether the responsibility extends to the client system, and on what basis and at what point informing members of the client system is warranted or necessary, is less clear. Finally, the consultant's option to withdraw services if resolution of conflicts between the consultant and consultee cannot be reached, raising the basic question about the limits of the consultant's responsibility for the consultee's actions, receives divided opinion.

Responsibility for recommendations and proposed solutions.

Discussion of this aspect of responsibility for outcomes has centered around four areas of ethical consideration. The first pertains to the presentation of alternatives. Here the consultant needs to present as many realistic alternatives as possible for the consultee to choose from, as well as presenting a clear rationale for any advocated position including suggested means of implementing such a solution (Zaltman and Duncan 1977). In helping the consultee consider alternatives, the consultant needs to act as a "problem-solving supporter" rather than a "problem-solution advocate" (Lippitt 1983). Furthermore, some suggest (e.g., Kelman 1965) that the target group should be involved in the change process as much as possible through direct communication or other means.

The second area involves the need to present to the consultee the potential risks of alternative solutions or action steps. Failure to consider with the client possible negative side effects is among the ethical standards of special concern to OD consultants reported by Glaser (1981). Gallessich (1982) writes that the consultant should inform the consultee of potential risks of the consultation, and should be aware of the condition of the consultee and consultee organization so as not to move in directions that might prove destructive. In a similar way, Lippitt (1983) suggests that the consultant explore potential consequences and risks of alternative actions with the consultee and act as a supporter, both affectively and methodologically, during the consultee's risk-taking confrontations with the larger system. In

general, consultants need to be aware of the possible side effects their interventions may have on the consultee (Fanibanda 1976).

The third area of consideration involves the question of consultant responsibility for negative side effects. Zaltman and Duncan (1977) have raised a number of questions concerning the responsibility of the consultant for the impact of changes once implemented. What is the responsibility of the consultant for unintended dysfunctional effects of interventions? Is the consultant obligated to provide assistance regarding these matters? This matter may need to be addressed in the initial contract and through the thorough presentation to the consultee of potential risks of various action steps. Whether the consultant has further obligations in these situations is a question that requires further deliberation.

The fourth area of consideration pertains to the issue of responsibility for followthrough. Different positions have been stated regarding this aspect of consultant responsibility. Fanibanda (1976) writes that professionals (consultants and consultees) must assume responsibility for their own behavior, and that if one assumes a strict definition of the consultant role, that "one does not actually give 'advice' for which one can be held responsible in the future" (p. 548). However, he does state that this matter of responsibility must be clarified in the initial contract. Kelman (1965) takes a different position. He feels that the responsibility for uses of information is the problem both of the contracting organization and the individual who supplied the information. In his view, the consultant should stay in the application phase if possible and carry a special sense of responsibility for ways knowledge and information might be used. Glaser (1981), as well, reported "failure to plan with the client for necessary follow-through" as an ethical standard of special concern to OD consultants. Paralleling these considerations is the question of what responsibility the target system itself has in helping people deal with the impact of change (Zaltman and Duncan 1977). Overall, as in the above areas, the central issues have to do with identifying and defining the boundaries of the consultant's responsibilities in a process that will contain numerous ambiguities, and how the understanding of respective responsibilities should be clarified with the consultee.

Responsibility for evaluation. A topic of special relevance to the issue of consultant responsibility for outcomes is that of direct evaluation of impact. Many writers believe that the consultant should make efforts to evaluate outcomes and to assist the consultee in making use of the findings (Bowen 1977; Gallessich 1982). Bowen, moreover, sees evaluation as a collaborative effort

between the consultant and consultee, but because many consultees do not care about evaluations and do not have the technical expertise to design and carry out evaluations, collaboration is often difficult. Consultee reluctance toward evaluation is paralleled by that of the consultant. Among the special concerns to OD consultants reported by Glaser (1981) was "resistance by the consultant to evaluation of his/her own consulting efforts" (p. 14). One possible contributor to this problem has been identified by Campbell (1973) and Tichy (1974). They see the change agent as often an advocate of a social innovation or new program. What this can lead to in any change effort is a tendency toward overadvocacy or exaggeration of the likely benefits in order to "sell" the change. As a result, the change agent and those within the system who support the change will have vested interests in avoiding evaluation. This factor, along with the general tendency to avoid evaluation of performance and the methodological difficulties in designing and conducting a valid and useful program evaluation, makes direct evaluations of outcomes a rare occurrence. Although these are serious barriers to overcome, the general ethical advice found in the literature is that the consultant should make concerted efforts to evaluate the outcomes of consultative interventions.

Professional Standards in Relation to the Ethics of Consultation

With the further establishment of consultation as an area of professional practice and the articulation of ethical issues to be considered as a part of that practice, the question remains of how best to encourage and maintain ethical behavior in the provision of consultation services. Three matters have been considered in this regard: ethics codes, enforcement of standards, and training.

Ethics Code

A primary method within the professionals for defining standards of practice and professional conduct has been the development of a code of ethics (e.g., American Psychiatric Association 1978; American Psychological Association 1981; National Association of Social Workers 1980). The most commonly stated purpose of codes is the protection of the client. Gallessich (1982) writes that a major reason for codes is to protect the client who is at a disadvantage in power and expertise. Flores and Johnson (1983) agree that clients lack the information and skills to defend their interests in dealing with professionals, and that codes protect these clients.

Ideally, then, ethics codes establish clear boundaries and definitions regarding the professional's role as well as what is and is not considered ethical behavior. They can then serve as a standard against which professional actions can be compared. To date, a code of ethics specific to the practice of consultation has not been developed by any of the major professional organizations. The National Training Laboratory Institute and the American Society for Training and Development do have codes, but their focus is limited to laboratory training (Gallessich 1982). This inattention to ethics codes in the field of consultation may be due to a lack of interest or to a perceived lack of usefulness and appropriateness of the codes themselves.

In this regard, Shore and Golann (1969) completed a survey of members of the Division of Community Psychology of the American Psychological Association. While the response rate was low (8.2 percent), the results are interesting. Respondents felt that the codes were helpful in general, but that they would not be of much help in specific cases. Models from industrial psychology were seen as more helpful than clinical psychology models in the area of consultation. Zaltman and Duncan (1977) report a comparison of codes of the American Marketing Association, the Market Research Society, the American Psychological Association, the American Sociological Association, and the American Association for Public Opinion Research regarding data gathering. Across three categories--the right to choose participation, the right to safety (protection of privacy and well-being), and the right to be informed--they found that the American Psychological Association offered the most protection, but that none of the codes was completely comprehensive.

Numerous problems have been raised about ethical codes. Many take the position that codes of ethics are just not very useful (Abbott 1983; Begtrup 1982; Caws 1978; Kurzman 1983). Daniels, in a Hastings Center Report (1978), stated, "Codes of ethics are window dressing. People who are going to behave well will do so and people who will not are not going to be bound by a code of ethics nor are they going to see that it applies to them particularly" (p. 22). He goes on to argue that ethics codes work only when they are backed by more powerful sanctions than losing membership in a professional association; e.g., fines and bad publicity. Another major barrier to the development of ethics codes is that practitioners are drawn from numerous rather than single primary professional identifications (Benne 1959). As Fanibanda (1976) indicates, codes are professionally defined, but consultants come from many professions, so the relevance of codes is low. In addition, codes do not take into account the special dilemmas of those professionals who are salaried employees of organizations (Wand 1981). Finally, Gallessich (1982)

points to a barrier inherent in the consultative work itself. That is, the complexity of the consulting process and its context makes it difficult to develop a code of ethics that will cover all contingencies. This complexity also has produced conflict within the profession regarding the boundaries of the consultant role and, therefore, differences concerning what is and is not ethical.

A number of directions have been suggested regarding ethics codes. Perlman (1977) advocates the development of a set of "secondary principles" to cover the special issues of community mental health. A survey of Division 27 (community psychology) membership of the American Psychological Association revealed a desire for more exemplification of standards derived from community practice (Golann 1969). The findings indicated a need for something like the APA Casebook on Ethical Standards, but specific to community psychology. Finally, Benne (1959) calls for more effective professionalization of consultation services and suggests three directions: (1) to develop and utilize "technical" and "ethical" languages; (2) to form cross-professional associations of consultants who can develop general "advices" regarding ethical problems; and (3) to work toward ethically right and technically effective consultant-client relationships.

Enforcement of Standards

There is a wide range of problems that limit the extent to which ethical standards can be enforced. The first is that professional activity is for the most part unobserved except by the client. Unless a client is aware that a particular action violates ethical standards, chooses to do something about that action, and knows what to do about it, the behavior will go unnoticed to the outside world. To a very large extent, this situation places major emphasis on self-discipline with all its inherent limitations.

Second, there is the problem of the level of effort and intrusiveness necessary to enforce a code of ethics. Zemlick (1980), in commenting on the ethics code of the American Psychological Association (1977), writes, "The energy, costs, and interference with personal goals implied in effective self-regulation are much more than most psychologists are willing to pay" (p. 449).

Third, the existence of ambiguities about aspects of professional practice leads to low consensus on certain ethical issues and makes enforcement more difficult. Tymchuk and colleagues (1982), in a survey of psychologists, found reasonably high consensus on clinical ethics issues, but less consensus on issues where guidelines are not clear. There was generally good consensus regarding sexual behavior, confidentiality, and dangerous clients.

However, there was poor consensus in areas of advertising, research ethics, tests and measurements, and fees. Fifty-eight percent of the survey sample reported that they are not well enough informed about ethical issues, and 89 percent felt that training in ethics should be required in graduate school. The extent to which consensus is low regarding aspects of consultative practice obviously reduces enforcement capability.

A fourth factor limiting the enforcement of ethical standards is the issue of confidentiality. The reporting of serious ethical misconduct in colleagues, although required by ethics codes, also is prohibited by confidentiality provisions of the same codes, and is influenced by professional etiquette (Stone 1983). Peer reporting also is complicated in situations involving competition (London and Bray 1980). Pursuing the exposure of a colleague will require the support of the client, and public exposure of the client. As a possible resolution of this situation, Stone advocates bringing in a third party, a consultant, to pursue the investigation. How effective this approach would prove to be is unclear. A final problem raised by Sabshin in the Hastings Center Report (1978) is the absence of effective enforcement procedures that can be applied in relation to professionals who are not members of professional associations. It is not clear in these situations what regulatory systems come into play. To the extent that professional review and regulatory bodies can be effective, this impact obviously is eliminated if the group has no defined authority in relation to a given practitioner. Overall, as Gallessich (1982) recommends, enforcement, to be at all effective, must occur at three levels: self-discipline, informal discipline (peer review), and formal discipline. This multilevel approach seems most realistic given the necessity for action on the part of the individual practitioner, peer group, and profession/society.

Training

Consultation and other community interventions are increasingly emerging as specialized areas of professional practice which require specialized training. In the Shore and Golann survey (1969), many respondents felt that mental health consultation was a difficult and specialized activity that needed much better specification of necessary training. Kurzman (1983) says we are moving into foreign terrain as professionals move into nontraditional types of service delivery and settings, such as private industry. The professional codes may be very helpful, but related training, supervision, and peer consultation need to gear up to help resolve dilemmas.

A number of problems, however, have been raised regarding training. Myers (1982) indicates that political and economic factors, especially third-party payment, have moved psychological accreditation, training, and other issues to more conservative "guild protection" positions, which are (1) conservative--emphasizing past training; (2) suppressive--with many required curriculums and experiences that reduce innovation; and (3) limiting--by allowing access to a wide range of professional activities only to "qualified" members. Because reimbursement eligibility is determined by credential rather than competence, development of new approaches, use of helpers with nontraditional backgrounds, or innovative training are very unlikely.

Stating a rather pessimistic view of training, Zemlick (1980) writes, "It is questionable that professionals can be trained to behave ethically since the qualities of integrity, honesty and responsibility are shaped in the earliest developmental years. Thus, only candidates with these qualities should be selected for training" (pp. 452-453). It is not clear what the selection procedures and criteria would be to implement this recommendation. Besides, Zemlick does go on to say that training can be useful in reinforcing ethics.

A majority of authors continue to argue for an increased focus on ethics in formal training programs. Studies have shown that there is only a limited emphasis on ethics in graduate psychology programs (DePalma and Drake 1956); more schools now include ethics in their curriculums, although apparently without much enthusiasm (Zemlick 1980). Benne (1959) feels that more training is needed for consultants in both the preservice phase and as inservice training. Such training would include role-playing, workshops, and supervision, and would give attention to both the technical and ethical aspects of consultative practice. Gallessich (1982) and Golann (1969) both emphasize the need for ethics education as part of training programs, although Gallessich sees such training as being of limited value without the development of a code of ethics.

Finally, Caws (1978) discusses the problem of teaching ethics in a pluralistic society. He argues that we have a pluralism of values, not of morals. Therefore, training should start with the basic moral principles that, although simple, still need to be transmitted across generations, and then move to elaborating the complexities. Caws states that professional ethics should be taught by including "a vivid sense of what the consequences of various courses of action actually are, and also a first-hand direct and personal acquaintance with the classes of persons likely to be affected by the professional decisions in question" (p. 39).

Conclusion

It can be seen from the preceding review of ethical and professional issues in mental health consultation that determinations regarding ethical conduct and moral obligation are exceedingly complex. Questions of ethical behavior often arise in situations involving multiple parties with competing values and agenda. Although there is some general consensus regarding a variety of ethical issues, there are a greater number of cases in which ambiguity and conflicting opinions remain. Recognizing the multifaceted context in which consultation occurs and the degree of variation among consultative interventions, the field is currently searching for a middle ground between universal and situation-specific approaches to ethical standards--that is, to establish general principles that must be understood and applied within varying contexts. As noted earlier, a focus on situational ethics places great emphasis on self-discipline. A consensus on clearly defined basic principles, which would make this self-discipline somewhat easier, has not yet been achieved. The literature suggests that steps toward that consensus will require further work on the following:

1. The articulation of general ethical principles specific to consultation, either in the form of a code of ethics (as Gallessich argues) or of general "advices" (as Benne suggests);
2. The development, both within and across professional groups and associations, of methods for review and enforcement, which will come to terms with the many problems and limitations of any enforcement system and be realistic about what enforcement procedures can accomplish, and place emphasis on multilevel approaches (individual self-discipline, peer group review, formal sanctions from professional associations, State licensing bodies, and the legal system); and
3. A more concerted emphasis on training in ethics at all phases of professional development, both as an integral part of formal training programs and as a topic for conferences and continuing education.

Consistent with the conceptual framework presented in this chapter, progress in the above areas will best be accomplished if attention is given to the contexts in which consultant-consultee relationships are most often embedded in professional practice. As we have indicated, the multilevel character of consultation creates ambiguities regarding the mutual responsibilities and

obligations of the various parties, can lead to unclarity regarding to whom the consultant is responsible, and requires the consultant to continuously manage the competing interests of subgroups within the organization. Similarly, the complexity of the organizational, interorganizational, and community contexts surrounding the consultative relationship, and the various subgroups represented within each of these sectors, means that there are multiple sources of value incongruence. As a result, decisions about ethical behavior on the part of the consultant and consultee occur within a field of multiple and competing values. This same multi-party situation greatly influences matters of confidentiality, making it difficult to establish clear boundaries around the consultant-consultee relationship and to balance the individual's right to privacy and the organization's need for information and open communication.

Ethical dilemmas about competence and resources in consultation are also complex. Individual judgments can be influenced by a variety of pressures emanating from the surrounding organizational environment. These pressures serve to increase the likelihood of misrepresentation as well as the possibility that consultants will exceed the limits of their capabilities or resources. Finally, in relation to responsibilities for outcomes of consultation, the consultant's and consultee's actions clearly have the potential to have impact on numerous individuals and groups both within and outside the organizations they represent. Therefore, considerations about outcomes need to involve awareness of all those who might be affected by a consultative intervention and of how their interests will be taken into account.

Consideration of the consultative relationship from the perspective outlined in this chapter provides a basis for a comprehensive understanding of the nature of the ethical dilemmas most frequently encountered. Applying an ecological framework helps to explain the complexity of consultation practice and, in turn, will best inform the generation of useful ethical guidelines, the development of realistic methods of review and enforcement, and the design of effective training in professional ethics.

¹This position is often presented in international journals, particularly by those who advocate more absolute ethical anchors as a counterweight to the effort by national political forces to use social science for repressive ends (Diaz-Guerrero 1979; Mailloux 1979; Nuttin 1979; Tomaszewski 1979). They see danger in a "neutral technology" approach to consultation.

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PART V

RESEARCH AND SPECIAL AREAS

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CHAPTER 15

RESEARCH IN MENTAL HEALTH CONSULTATION: EMERGING TRENDS, ISSUES, AND PROBLEMS

Kenneth C. Kenney

This chapter reviews the major trends which have taken place in mental health consultation research from three perspectives: a critical review of research studies, issues and problems in the conduct of the research, and future directions. Obviously, no one chapter could provide a comprehensive examination of all the research done in this field--such a task would more properly be the goal of a separate monograph. What can be accomplished is to provide an outline of the key issues and a perspective for the complementary chapters in this book.

Critical Review of Research Studies

To appreciate the scope of mental health consultation studies, it is important to review three broad areas: the areas of consultation which have received attention in the literature, selected topics of mental health consultation, and the major forms of mental health consultation.

Major Focuses of Research

Researchers have conceptualized mental health consultation as a major form of intervention in hospitals, schools, mental health centers, and other human service and business settings. As such, their efforts have extended from general research on the process and outcome of consultation to program-oriented research. Many of these activities are narrowly focused (for example, looking at the role of the consultee in a particular situation); others view the broader social and environmental implications for consultation.

Research on the consultation process. The literature on the process of mental health consultation reflects the continuing growth of knowledge and specificity in the field itself. Early works examined process dynamics and specific process phases (Broskowski et al. 1973; Lippitt 1959; Goldstein and Marshall 1971), while later works looked at the process dynamics relevant throughout various process phases (Friedman 1976; Stevens 1977).

Two findings have emerged as most important to the process of consultation. The first is that consultation services must be perceived as relevant to the consultee's needs. The second is that the planning of the consultation must include an assessment of the consultee's needs and interests. For example, consultation problems occur when the consultant tries to impose arbitrary solutions having no bearing on the client's problem, such as the consultant who recommends the use of one specific technique to all consultees, whatever the problem the consultee presents (Dimma 1977; Frankenhuis 1977; Larsen 1982). Also, because the consultant and the consultee can be expected to have different expectations of consultation, an assessment of the client's needs and interests is critical to what happens in the consultation. For example, if the consultee looks upon the consultant as having special substantive knowledge, dissonance can result when the consultant focuses exclusively on process issues. Similar difficulties have been noted when the consultee seeks more effective direct services for a client (food, housing, health care) while the consultant believes that the consultee wants supervision about the client's insights and motivations (Cherniss 1978; Goldman and Cowan 1976; Heron and Catera 1980).

Research on consultation outcomes. Research on the effects or outcome of consultation can be grouped into studies of change in four areas: the consultee, the system, the client, and a combination of these entities. Some form of goal attainment assessment is the most common way used to answer outcome questions in mental health consultation.

As applied to the consultee, most studies looked at whether an increase in knowledge and skills enhances effectiveness on the job. Studies of change in the consultee have dealt with changes in group behavior (Fisher 1972) and in individual professional development and functioning (Newfield 1972; Martin 1975). Consultation appears to be most effective in helping consultee functioning in the areas of empathy, values clarification, and overall sensitivity. Larsen (1982), though focusing on the effects of program-oriented technical assistance consultation, has reached similar conclusions about the impact of consultation on consultees. Similarly, Strommen and Aleshire (1979) examined what in the consultation was most likely to contribute to success; they concluded that the affective, or interactive, skills imparted to consultees found the most acceptance and the most persistent utilization. The findings show that consultation itself is not a critical contributor to the direct enhancement of work skills. Rather, consultation has a more pronounced effect on increasing the consultee's readiness to learn new skills. Over a decade ago, Silverman (1974) discovered the importance of the consultation itself in promoting motivation for new learning; a consultee's favorable perception of the

consultant set the stage for skill acquisition. Ritter (1978) found that the consultation process developed consultee coping and problem-solving skills. His assumption, dramatically demonstrated, was that successful consultations result in decreased use of consultation services. By holding other variables constant, he was able to show how consultees (in his study, teachers) needed fewer consultations as their newly learned skills increased.

Concerning mental-health-related changes in the institutional structure, or the system, early research studies are rare and their results equivocal (Foster and Hartman 1959; Berk 1972). Recently, system-focused research has accelerated, demonstrating a growing awareness of the role of consultation to systems (Goldman and Cowan 1976; Larsen and Morris 1977) and the importance of social system influences (Zuo et al. 1985). Agency attitudes and expectations influenced the effectiveness of the consultations; these results take into account the cognitive characteristics and the readiness or participation "set" that may exist in a system (Cherniss 1978). These studies show that the success of a consultation may be more dependent on a system's attitudes and corporate myths than it is on characteristics of the consultant or consulting methodologies.

Changes in client behavior are another important measure of consultation effectiveness. Early studies could not clearly demonstrate this effectiveness (Eisenberg 1968; Chapman 1966; Conner and Thoresen 1972; Hunter and Ratcliffe 1968); vaguely developed associations among variables resulted in findings that were too flawed to be conclusive. Studies have become more precise in detailing the connections among specific relevant variables, but there has been little added to our knowledge of the total change process. If the spread effect of consultation depends first on changing the consultee so that the client may be changed, how are the elements of consultee change to be specified? Must consultee attitudes change before behavior can change? This assumption has not been tested. Even if there were a consistent effect, what are the change points between attitude modification and behavior alteration? These issues remain unresolved.

The most hopeful findings are in the area of behavioral consultation within the school, where the most rigorous documentation exists for direct change in clients (Medway 1979). In the school studies which Medway examined, consultation was seen to be effective in modifying the behavior and attitudes of consultees and their clients; moreover, school personnel appear to have accepted consultation as useful, especially behavioral approaches. Larsen (1982) considered a broad range of mental health consultation; her conclusions are consonant with other available evidence on the impact of consultation.

Specific characteristics of both the consultant and the organization contribute to successful outcomes. Successful consultants demonstrate technical knowledge, ability to clarify the problems and priorities to be addressed by the consultation, ability to present multiple alternatives rather than one "best" solution, and ability to provide support for the organization's problem-solving efforts. Characteristics of the organization found to be significantly related to outcome included receptivity to a consultant's input and perceived need within the organization for consultation, as well as at least a tentative commitment to program modification, consideration of adaptive alternatives, and some preliminary planning. Also, Larsen found that sufficient time must be allowed for the implementation of program modifications; impact should not be measured for at least 8 months following intervention. These findings, though tentative, are exciting, and they incorporate the basic research which pointed the way in earlier studies. Continued research is required, but it is becoming more and more clear which aspects of consultation are effective under what circumstances.

The final look at outcome effects focuses on changes in a combination of the client, the system, and the consultee. For example, an early study of this type (Schmuck 1968) tried to assess the effects of mental health personnel (the consultants) upon teachers (the consultees), their students (the clients), and their classrooms (the system). Few changes in the clients or the system were noted, although the consultees showed some effects of the intervention. The design problems pointed out by the researcher emphasized the need for more tightly drawn approaches to demonstrate combination effects. In controlled studies where the changes in recipients were more clearly detailed, positive effects were demonstrated (Jeger 1977; Keutzer et al. 1971; Ivanoff 1977).

Where less clear distinctions are made within the studies themselves about who are the recipients, the results are less useful. For example, many studies claim to measure changes in the system and in the consultee. However, given the conceptual and practical difficulties in separating systems and the people who make them up (the consultees), the lack in functional definitions has resulted in less generalized findings.

Another problem in combination studies is that few designs acknowledge that systems operate at many levels; change at one level does not necessarily translate into change at all levels. Although a study might be able to demonstrate that a change in hierarchy may bring about a change in worker productivity, there is no automatic implication that some other system interaction (e.g., open communication) would effect the same result. Once

again, as studies have become more precise in making such distinctions, their results have become more useful (Hill 1977; Holahan 1977). Unfortunately, no consistent results have emerged, mostly due to the paucity of studies and the wide variety of the systems examined.

Nevertheless, several useful guidelines can be drawn from these research attempts; moreover, these same guidelines have relevance for all research on the effects or outcome of consultation. The first is the need for clear definitions. Service recipients must be defined, and the study needs to outline the nature and the character of either the problem to be addressed or the consultation intervention to be made. Similarly, the expected results at each level of change need to be described so that changes can be assessed and the measurement instruments developed. Finally, in addition to recipient changes, there needs to be a clear conceptual and functional link detailed between what changed and what was expected to change. Attention to these guidelines--which have emerged from previous research attempts--will help to further ground any outcome research in mental health consultation.

Research on program consultation. Program consultation deals with the planning, development, management, evaluation, and coordination of services directly or indirectly affecting the mental health of the community. The clients of such consultations are usually administrators and planning staff. Research on program consultation covers two broad categories: research on a particular program element, such as consultation with management or with planning; and research on training programs, such as consultation between mental health professionals and teachers. This aspect of training, which is specific to program-oriented research, is treated separately from other training issues. The aspects of training here addressed have direct impact on program management in that they focus on program-oriented issues such as planning, development, and coordination.

Significantly, most of the research in this area is the result of program evaluation efforts. Whereas the goal of research is to expand the base of knowledge, the goal of evaluation is more likely to be improved decisionmaking in the program under examination. Program evaluation has many similarities to the research on psychotherapy: even the best designs are quasi-experimental, and confounding variables abound. To this extent, studies on program consultations have even more methodological criticism to overcome than other consultation studies. This distinction may be more academic than practical; findings, whether from evaluation or research, will be subjected to the same scrutiny and critical analysis before they are incorporated into what is known about mental health consultation.

Program consultation research includes outcome studies (did a particular program or program element work?), process studies (how can we modify this ongoing program?), consultee satisfaction measures, and program pilot studies. As mentioned above, there is also a body of research which concentrates on the quality and effectiveness of training programs. The great majority of research articles in this area involve interventions or programs in educational settings; the remaining research examines program consultation in health and mental health, industry, the military, and social service organizations. Many interesting findings have emerged from the school program consultations, although most studies are so case- or program-specific that they are not generalizable. Studies in this area have examined the relative benefits of client-centered group work versus behavioral management (Randolph and Hardage 1973); productivity benefits from different teacher consultation techniques (Brown and MacDougall 1973; Fairchild 1976); and evaluations of feedback systems, outcomes, and processes of program consultations (Schmuck et al. 1975; Kelman and Wolff 1976; Emiley et al. 1975). Consultation results have generally been found to be positive.

Program consultation research outside the schools has looked at the same success of consultation and education services (Weber 1974), organizational utility (Hansen and Bentley 1976), the quality of work life (Glaser et al. 1976), characteristics of program consultants (Alpert 1981), and information use effects (Butler 1975). Once again, program-specific positive effects are frequently seen in these studies; several general trends and indications that have emerged are summarized at the end of this consideration of program consultations.

Research on training programs can be grouped into two categories: evaluations of training programs for consultants and research measuring the effectiveness of consultant-run training programs for consultees. Studies examining consultant training programs have produced findings on such topics as training effectiveness, program evolution, materials and instrumentation, training techniques, duration and intensity of participant involvement, and behavior change (Drapela 1985; Green and Arends 1976; Goodwin and Coates 1974; Harris et al. 1975; Walsh 1973; Stratford and Ward 1975). Those program consultations which assessed the impact of the training program on the consultees have looked at changes in work behavior, attitudes, or expectations; service improvement; training approaches; and the planning of training (Broskowski et al. 1973; Daggett et al. 1974; Levine and Brocking 1974; York et al. 1975; Heron and Catera 1980).

Before summing up the most general findings of these studies in program consultation, one of the most productive fields to have

emerged in this area will be highlighted--namely, research on technical assistance consultation. Specific to work-related problems, technical assistance (from the Federal level down to the program level) grew in scope and importance along with the community mental health movement. Research on these efforts is limited, but the findings have direct impact on the utility of program consultation. The importance of time spent in program development and the importance of consultant legitimacy have been emphasized in these studies (Larsen 1982; Cobb and Medway 1978; Strommen and Aleshire 1979). Probably because of their specificity about levels of change and their explicit definitions of study topics, this aspect of research has provided many of the most promising findings and approaches in the field of program consultation research.

Conclusions about program consultation must be tempered with all the methodological cautions which pervade this review. However, some useful generalizations, trends, and guidelines have emerged. Personal attributes or characteristics of the program consultant appear to be very important. These include technical knowledge, negotiating ability, empathy, support, availability to the program's staff, and a special skill to come up with creative alternatives which combines what the program needs with program perceptions of what can be done.

A set of organizational attributes have also been seen to affect program consultation outcome. Readiness or receptivity to change, perceived sense of need for change, a commitment to change, and ability to make changes all influenced effective program consultations. An overriding element of organizational willingness to change was seen in the need for sufficient time--on the order of 8 months--to allow changes to show up.

Trends noted in these studies include the recognition of multivariate approaches and time-series designs as the most comprehensive and relevant techniques for measuring program change.

Major Topics of Research

Based on a review of study topics appearing in the research literature, it is possible to identify those topics of mental health consultation most frequently addressed. These include (1) the roles and functions of the consultant, (2) selection of the consultant, (3) personal characteristics of consultants and consultees, (4) characteristics of various mental health consultation settings, (5) problems precipitating the consultation, and (6) cost-effectiveness of consultation.

Roles and functions of the consultant. Early research on the roles and functions of consultants suffered from the lack of consensual and operational definitions of mental health consultation. Traditional, clinical, and psychiatric models of consultation (e.g., Krakowski 1975) examined the roles and functions of the consultant very differently from models which looked for the spread effect in community settings (e.g., Mann 1978). This absence of criteria produced studies which characterized mental health consultation as "old wine in new bottles." As role expectations became more clear, the research began to reflect the usefulness of the slowly emerging distinctions. Consultants in schools, mental health centers, and businesses have received the most attention. Role conflicts in schools often arise between teachers and their consulting psychologists. Teachers typically look to consultants for specific remedial and behavioral advice, whereas psychologists often see their role as more diagnostic, heuristic, and general (Gilmore 1974; Lesiak and Lounsbury 1977; Penn 1977).

In mental health settings, the tension is between those who seek prescriptive and expert advice and those who seek to point out preventive and generalizable approaches. This has seldom been studied directly; thus information about such role expectations must be inferred from research on consultant/consultee relationships (e.g., Cherniss 1978). Similarly, the business-related literature indirectly points out the need to have clear role expectations by its focus on what to look for in hiring a consultant (e.g., Frankenhuis 1977).

Summing up the research findings about role expectations, most studies emphasize the need for the consultant and the consultee to clarify their expectations. To this end, one finds an equal emphasis on the need for specific inservice training to consultees about consultation and for needs assessment and values clarification as an element of any consultation.

Selection of the consultant. Selection of the consultant has received a great deal of attention in the business literature and, to a lesser extent, in school studies. Issues usually identified include expertise of the consultant, organizational readiness for consultation, personality characteristics of either the consultant or the consultee, and the congruence of goals among all participants in the consultation (Alpert et al. 1977; Alpert 1981; Davidson 1973; Frankenhuis 1977; Gumaer 1980). Once again, little specific information about selecting a consultant has emerged apart from the more general studies of consultant-consultee relationships.

Personal characteristics of consultants and consultees. The personal characteristics of consultants and consultees have been

another major focus of consultation research. Perhaps personal style receives so much attention because of the profoundly interpersonal nature of consultation. Much of the research in this area has examined the personal attributes of consulting parties in relation to client satisfaction and consultee effectiveness. As has been noted, the implications of these studies extend to issues of role definition and consultant selection. If, for example, a consultee wants expert advice about a specific problem, both the role of the consultant and the nature of the relationship will have a bearing on the results of the interaction. Similar problems of role definitions, selection, and consultant-consultee relationship can be expected when a teacher group seeking general information about classroom management contracts with a clinical psychiatrist.

The consultant-consultee relationship has been identified as key to successful consultations (Medway 1979; Meyers et al. 1978). It is interesting to note the number of studies containing observations of consultant-consultee "tension" (e.g., Meyers et al. 1978). One could get the impression that a great deal of consultation is arbitrarily imposed and unpleasant, given the number of studies that analyze interactions characterized by hostility and mistrust. Much of this can be attributed to problems with role expectations.

For whatever reasons, the relationship between consultants and consultees appears to be crucial to outcome; research in this area has both direct and extended relevance. Several general findings emerge. Clearly, for consultation to work, there must be a high level of congruence between the role expectations and the task perceptions which the consultant and the consultee bring to the relationship. The more time they spend together, the more likelihood there will be of a favorable outcome. Age, sex, professional training, and therapeutic orientation have all been examined as possible determinants, but the distilled results are either contradictory or equivocal. The consultant-consultee relationship appears to be one of those issues which is clearly important but hard to analyze.

Characteristics of settings. Various settings which host mental health consultation have been the subjects of research studies to determine whether there are similarities across settings or if there are characteristics unique to specific settings which must be taken into account in determining consultation strategies. Settings studied include mental health centers, schools, hospitals, government offices, military establishments, and businesses. The research itself has produced little in the way of similarities or differences which would inform future setting-specific consultations. However, a process assessment of these studies reveals some general trends. Schools and mental health centers are at once the largest consumers and suppliers of mental health

consultation, though other human service agencies and business settings are seeing increased consultation. The focus of consultation is expanding from individual or problem-focused consultation to more emphasis on the system. Multiple levels of intervention seem to be a frequent goal of consultation, and there appears to be a growing awareness of the interactive effects of person, setting, and environment.

Problems precipitating the consultation. Likewise, the problems precipitating mental health consultations have changed over time. Unfortunately, no research was found which specifically addresses this area, which would provide a rich source for study. A pattern is discernible, though, which demonstrates a growing appreciation of what consultation can bring about. This development extends from the examination of individual problems in contrived clinical settings to interventions designed to ripple through an entire system, producing wide-ranging effects. Early consultations generally focused on an expert giving advice about a particular client. More recently, consultations often have attempted multileveled interventions whose goal was a broad treatment of issues and actors and which recognized the interactive components and the possibility of spreading the effect of the consultation as far throughout the system as possible. There is little information as yet about which kinds of problems are most amenable to which kinds of consultation. But as consultation continues to develop, research in this area is likely to follow.

Cost-effectiveness of consultation. The final topic that has been considered by many researchers is the cost of consultation relative to other mental health interventions. The ripple effect of consultation is assumed to make it cost-efficient, since the results are supposed to spread widely. Cytrynbaum (1974, 1977) broke down the component elements of consultation into functional units: criteria for adequacy, effectiveness, data collection stages, and feedback procedures. Clinicians used this approach to make decisions about time; administrators turned the time elements into cost estimates. Tippet et al. (1974) suggest a similar functional job analysis to allow the actual and indirect costs to be assessed. Another approach is goal-attainment scaling (Taylor and Vineberg 1978), which involves project contracts and multiple measures. Costs can be derived from any of these approaches. Though the aforementioned studies attempted to produce levels of effort and measurable units of service directly, they can serve as a model for those methodological considerations underlying the cost of mental health consultation and its importance to research.

Major Forms of Mental Health Consultation Research

Mental health consultation research has employed a variety of methods and tools, including review summaries, surveys, case histories, and innovative technologies.

Review summaries. Several books and articles have reviewed various aspects of mental health consultation. Though not all have been directed at research, they cover most of the issues which need to be examined. The task of the review summary in mental health consultation is difficult because of the wide range of issues and the lack of consensus about variable description. This calls for a level of analysis and integration requiring substantial effort. Specific to mental health consultation were Ozarin's (1975) review of community mental health programs and the overview of Carter and Cazares (1976). Mannino, MacLennan, and Shore's (1975) book, The Practice of Mental Health Consultation, contains nine chapters focused on community mental health consultation, including a review of studies analyzing effects of consultation from 1958 to 1972. Findings and discussion of these outcome studies are also reviewed in Mannino and Shore (1975).

Reviews of mental health consultation in the schools are dominated by Medway's work (1979, 1982). The earlier work reviews 29 studies on the effectiveness of school consultation published between 1972 and 1977; the later work reviews and evaluates school consultation research conducted through the beginning of the 1980s. Alpert and Yammer (1983) performed a content analysis of mental health consultation research in the schools. They found a lack of continuity and followthrough in research on consultation, discrete studies rather than systematic or programmatic research, relatively unsophisticated statistical techniques, and a preponderance of behavioral studies focused on the remediation of individual cases, with most studies set in elementary schools.

Another important review of consultation effectiveness studies emerged in Larsen's (1982) synthesis of technical assistance research. In an effort to understand the nature and type of student research in consultation, Mannino and Shore (1983) reviewed doctoral dissertations through 1979. Authors of such reviews have brought together specialized and thematic information to describe what consultants do, how well they do it, and what makes consultation work.

Surveys. Survey research is well represented in the mental health consultation literature. Some studies focus on the need and use of consultation; others examine the impressions of either consultants or consultees. Studies on the need and uses for consultation services come largely out of psychiatry. Inadequacies in the

training of consultants and their use across medical specialties are a frequent theme of these studies (Forman and Hetznecker 1976; Krakowski 1974; Awad and Poznanski 1975). The authors call for specific training in consultation for consulting psychiatrists and for increased use of consultation by all medical specialties. One of the more productive authors in this area is Peter Brook (1974a, 1974b, 1975) who notes that psychiatrists require special training in geriatrics, medical-legal issues, and organizational dynamics before they hold themselves forth as consultants in hospital settings.

In terms of the actual and perceived need for consultation, Mazade's (1974) survey outlines the organizational requirements which must precede and attend the introduction of consultants, including system flexibility, time available for implementation and followthrough, and previous experience of the staff with consultants.

A major gap in this area of study is the lack of survey information on the need and uses for consultation beyond the hospital. Studies on schools, mental health centers, and the military focus on workers and clients, as if assuming that the need for consultation itself has been established.

Many of the surveys on consultants are difficult to distinguish from surveys about the needs and uses for consultation. For example, the previously cited studies by Brook and Mazade include the impressions of consultants, but they address themselves to the issues of need and use. Other consultant surveys examine what consultants do and what they think about it. Cook and Patterson (1977) surveyed school psychologists who spent most of their time on assessment but who believed consultation to be their most important role. Another important school survey (Gumaer 1980) identified the major functions of the consultant as help with self-assessment, with understanding the process of identifying prospective consultees, and with selection of consultants. In the business arena, Dimma (1977) and Tichy and Nisberg (1976) surveyed organizational consultants and executives and found agreement that the chief topics of importance were leadership, command of substantive information, and sensitivity to organizational dynamics.

Surveys of actual or potential consultees have demonstrated several relevant aspects of consultation. Mischley (1973) found that teachers differ in their expressed preferences for receiving mental health consultation based on their background, previous work experience, and organizational dynamics. Shafe (1976) surveyed teachers who desired that consultants address three major concerns: updating approaches for dealing with difficult-to-teach students, techniques for diagnosing behavior problems, and

techniques for effective behavior management. Among the most commonly described needs of teachers in Haughey et al. (1977) was help in dealing with the needs of special students. In an effort to find out more about what social work consultants actually do, Kadushin and Buckman (1978) surveyed 500 social work consultants. They analyzed arrangements and motives for consultation, identification of consultees, and typical examples of consultative intervention. Their results suggest that, although social work consultation can be identified as a distinctive process, it has yet to achieve a clear and stable image.

What is most needed in the survey research literature on mental health consultation is the administration of scales to specific populations and the matching of results with identified problems. Alpert's (1981) survey of the characteristics of consultees and consultants and success in mental health consultations stands almost alone as an example of pure survey research. She found that the more successful consultants had consultees who were more dogmatic and authoritarian, and were more dissimilar to their consultees in level of dogmatism and reported need for assistance. This kind of survey approach, using measures or scales on selected populations, should be encouraged as an especially effective way to establish consultation practice.

Case histories. The research on mental health consultation has both gained and suffered from case histories. The obvious problem with case histories is that the ideas that proved so successful in one county's mental health center do not necessarily transfer to other parts of the country. Consultation innovations in one satellite office of a large center may not work in other satellites of the same organization. However, the apparent ease of writing up a case study, coupled with the medical model's familiarity with this research form, has made it an attractive vehicle for many studies. On the positive side, some of the most interesting reading in this area comes out of the reports of people who were excited enough about what they found to want to share it.

Consultation research about specific school settings or issues has seen the greatest activity. In their study of doctoral dissertations about consultation research, Mannino and Shore (1983) found that 75 percent of the theses which specified settings were done in schools; this also reflects the overall distribution of case histories. Certainly in terms of the developmental and preventive issues congruent with consultation theory, this makes good sense. Also, in terms of the specific findings that can be tested out in more diverse contexts, these school studies are an important source of ideas. For example, the need for behavioral grounding of intervention and the importance of consultant legitimacy were findings from school case histories which were later proven useful

in a broader range of settings. The problems with these studies, as with most case histories, is that they are restricted to specific (and usually unduplicatable) sets of circumstances and are limited by small sample size. Moreover, consultations go on in a wider variety of settings than the schools can offer; even given the problems with case histories, it would be helpful to see them in other situations. Representative examples of case histories would include Kerlin and Latham's (1977) school study of a crisis resource program; Reinking et al.'s (1978) hospital-based report of consultation effects on nurse productivity; a case study of consultation effects on a specific issue/school phobia (Gresham and Nagle 1981); and Heron and Catera's (1980) study of functional and behavioral consultation approaches.

Innovations. Innovative technologies would seem to lend themselves readily to the tasks of mental health consultation research. Those selected include information retrieval systems, personal computers, and telecommunications.

One would expect that the growth and sophistication of information retrieval systems would have resulted in comprehensive survey and review studies. Yet only one such study could be found--Lindberg's (1975) doctoral dissertation on the use of a consultation case register. Many of the researchers cited in this chapter have used retrieval systems in support of their studies, but there is still a lack of systematic research on the special applications these tools can provide.

The use of personal computers in mental health consultation has been researched in the literature. Interestingly, what would today be a personal computer application was mentioned over a decade ago by Wilson (1973) who described the use of multiple terminals using a central mainframe to teach consultation techniques. Nowadays, this is a commonplace use of personal computers, and their application for this use has been studied. Hammer et al. (1985) describe the use of microcomputers in a general hospital to integrate the clinical, administrative, research, and education functions on a psychiatric consultation service. Strain (1985) reviews a study of a sophisticated research and screening use of microcomputers in a consultation-liaison setting. The problems and advantages of the use of computers in consultation-liaison psychiatry are summarized by Taintor (1985), who studied the planning and implementation of a personal computer system in a general hospital. A study on the use of a large mainframe computer system (Popkin et al. 1985) provides a plan for using computers in consultation.

Two articles describing the possibilities of telecommunications (Dwyer 1973; Straker et al. 1976) accurately predicted the

use of interactive television hookups between scarce experts in central locations and primary providers in outlying underserved areas. The effectiveness and practicality of such technology was assessed by Bergstrom et al. (1984) in the development of a consultation training program in rural areas. The availability of low-cost satellite dishes now makes this technology accessible in almost any geographical area, and more research on its advantages and limitations is eagerly awaited.

Issues and Problems in the Conduct of Mental Health Consultation Research

Throughout this chapter allusions have been made to the issues and problems encountered in the conduct of mental health consultation research. Many of these difficulties are similar to those found in any review of social science research; others are specific to the circumstances of mental health consultation. Rather than spotlight the inadequacies of individual studies, this section briefly touches upon the key issues and problems in the area.

This section begins with a treatment of several general consultation research issues: lack of historical perspective; the conflict between basic and applied research; the lack of a theoretical substructure; and the need for refinement of goals, values, variables, and measures. There follows a review of some of the design, timing and setting, and statistical issues found in current studies.

Lack of Historical Perspective

Several theoretical issues stand out as having an important bearing on consultation research. One is a very general problem which runs through much social science research--the lack of historical perspective linking present research to previous work in the field. Too many researchers have approached consultation as if they were the first to think about it. Not only have they failed to recapitulate what was already available in their own area, they have ignored the work done in relevant but unrelated areas. Thus such studies lack any synthesis of comparable effects and data.

Conflict Between Basic and Applied Research

The above-noted problem might be postured differently as the apparent conflict between basic and applied research. For both researchers and decisionmakers, there is a perceived lack of

congruence or compatibility between theory-oriented and practice-oriented studies. Both sides of this argument have cogent and compelling support, and it is likely that consultation research would benefit from both kinds of studies. What is important is that the researchers should have a clear idea of the context within which their studies fit; this may help them, when they present their findings, to place their results in the broader picture. The skillfulness of the researchers and the extent of their experience are closely tied to this problem. It has been mentioned several times throughout this chapter that few established scholars are making a primary research commitment to the area of consultation research. The weakness of many of the existing consultation studies can be blamed largely on the lack of skilled or experienced researchers. It can only be hoped that the growing acceptance of consultation will increase the incentives for research in this area and attract more seasoned scholars.

Lack of Theoretical Substructure

Another major problem of approach has been the lack of theoretical substructure to inform the design or purpose of consultation research. Even the definition of "mental health consultation" is still not firm. Other chapters in this volume describe the evolution of mental health consultation from a dyadic relationship between consultant and client to a triadic interaction among consultant, consultee, and client. This compelling conceptualization, which expands mental health consultation beyond the two-party or clinically oriented perspective, has important theoretical consequences for the conduct of research. It also has implications for the actors and consumers of consultation, for the goals and objectives of the consultation intervention, and for the purpose of the intervention. For example, is the goal of consultation to improve mental health services or to increase the revenues of mental health organizations? Is the consultation to focus on client change or on the roles of consultants or on the potential levels of intervention? Many studies are flawed because of ill-defined goals resulting from a poorly developed theoretical model. As congruence and specificity about the underlying theory have grown, the research about consultation has become more and more focused. Theoretical problems still exist, especially in the use of consultation in nontraditional arenas. Much of the flawed early research was the result of poor conceptualization, and the lessons from these studies can be applied or adapted so that future studies do not repeat the same mistakes.

Need to Refine Definitions

As with psychotherapy studies, mental health consultation research faces substantial scientific barriers. One of the earliest problems involved arbitrary nomenclature. Although generally agreed-upon definitions of the terms "consultant," "consultee," and "client" have been available at least from the 1950s, they have not always been followed. Likewise, the definition of "consultation" itself has suffered from ambiguity and lack of consensus. This reflects a conceptual problem, which in turn has implications for consultation models and for what is supposed to be measured. Closely connected to the absence of consensual definitions is the lack of clearly defined goals. For example, what is supposed to change following a consultation--values, attitudes, or behavior? Is the client supposed to be different? Should the organization show the effect? If so, at which organizational level? Without specific goals in mind, the study of the process is aimless. Although problems of this type were more common in earlier research efforts, this problem still can be observed, especially in those studies which lack an overview of the area.

Unclear Operationalization of Variables

A closely related problem has been the difficulty of putting the variables to work. The unclear operationalization of variables has led to much confusion about what the results of many studies imply. Many researchers have combined poor instrumentation with loosely drawn theory to describe the variables to be measured--for example, a study which sets out to demonstrate that a consultant with a particular therapeutic orientation can produce change in the consultee's clients. The outcome measure would be a change in the client's responses to a scale listing behavioral and attitudinal characteristics--the assumption being that client change indicates success of the consultation. Absent from such a study are the consultation theory being tested, the consultation variables under examination, and the relation of the variables chosen to the therapeutic approach selected. The reader may question whether this is a therapy outcome study or a piece of consultation research.

Certainly, many of the concepts and elements of consultation are difficult to put to work: verbal behavior, cognitive effect, attributional conflict, personal characteristics of the consultant, etc. A consistent failure in the attempt to define variables has resulted from the temptation to approach them as monoliths. Throughout the literature are attempts to account for cognition, process, setting, and communication with no acknowledgment that these are complex phenomena. Unsatisfactory measurement

scales have resulted. Few of these scales have been preceded by pilot tests or standardization.

The interaction between unclear theory, unclear goals, and poorly formed scales is evident in an unfortunate number of consultation studies. Problems include the following: data collected from only one actor in the consultation, only self-report data collected, only data from one level of the intervention assessed, only one dependent measure identified, extraneous factors ignored in the interpretation, and competing hypotheses never addressed. These complaints are frequently listed in research reviews, but fortunately, they are the exceptions to a body of work which, overall, has produced a sound literature that stands up to critique.

Design Issues

Research on mental health consultation includes an ambitious range of designs. The quality of studies is uneven, but a balanced analysis suggests that consultation has received a measure of research attention remarkably similar to other psychological activities. The span of approaches employed includes experimental, quasi-experimental, and correlational designs.

Experimental studies. Few strictly experimental studies in the area of mental health consultation have been carried out. Methodological problems weighing against such an approach include lack of agreement about variable definitions, sample size, and difficulties with maintaining controls. Another serious barrier to this approach is that few professionals have made a primary research commitment to the area; the basic research which would prompt experimental designs is less represented in the literature than are more pragmatically constructed applied studies. The studies with the best claims to experimental status have examined very discrete, lawful relationships among strictly defined variables (Marino 1976; Conrath et al. 1975). These and similar studies discuss the strengths of explained variances among such variables as specific behavioral techniques, process attributes, and organizational and consultant characteristics. The pressures on evaluators and researchers to demonstrate the effectiveness of consultation may have resulted in avoidance of studies such as these which produce important but restricted findings.

Quasi-experimental studies. Quasi-experimental approaches have found more favor than purely experimental approaches among both researchers and decisionmakers. One reason for this may be the popularity of Campbell and Stanley's Experimental and Quasi-Experimental Designs For Research (1963). The concepts and approach in this work have proven to be accessible to a wide range

of mental health workers and educators, thus accounting in part for the prevalence of quasi-experimental methods.

In addition, the nature of mental health consultation lends itself to the methodological accommodations made possible by these flexible designs. Indeed, the designs themselves and the cautions about validity expressed by the authors seem especially apt for consultation research. On the whole, the informed use of these designs has produced useful findings with the promise of more to come. Unfortunately, many well-intended studies which have tried to approximate quasi-experimental designs have fallen short of their goal. But the overall effect of these designs has been to stimulate innovative approaches, much to the benefit of consultation research.

Correlational studies. Though correlational studies are rightly a subtopic of quasi-experimental methods, they receive special attention here because of their popularity with many consultation researchers. Correlation is easily understood by decisionmakers, and it is helpful to frame research in a way that makes sense to the intended audience. Lawful correlation approaches make it possible to answer a question such as "To what extent do different professional groups react to consultation interventions?" A wealth of research has been produced and put to use on the basis of this kind of format (Medway and Forman 1980; Curtis and Watson 1980). The best of these studies present a plausible causal hypothesis to argue the interpretation of their correlation and explain the absence of a plausible rival hypothesis. This is especially important in consultation research, where it is easy either to overlook any one of a number of factors which may influence the results or to overemphasize a particular correlation based on limited interventions or observations. Well-constructed correlational studies with carefully drawn interpretations are invaluable; they deserve to retain their place in consultation research.

Timing and Setting Issues

When to attempt an intervention, when to measure it, and when to evaluate the results with decisionmakers are all questions relating to the timing of research. Since most consultation research does not take place in a laboratory, the dynamic considerations of organization timing must be introduced into the methodological formula. A very useful approach to this problem is the multiple measures used in program evaluation (Hagedorn et al. 1976): process measures (how did it happen?), outcome measures (what did it do?), and impact measures (how did it affect the organization?). Another approach would be to assess the timing of

the consultation at specific stages. Larsen (1982) found that the effects of a consultation require at least 8 months to work before they can be measured. No similar studies could be found, but it is important to examine timing issues such as these: How early in a program's development can a consultation be introduced? What criteria are most helpful in determining when to measure a consultation? And when is the best time for presenting the results of consultation research to decisionmakers?

Closely related to issues of timing are considerations of the setting where the consultation takes place: Does the size of the organization need to be taken into account? Do special factors obtain in schools, hospitals, and businesses which require separate approaches? What criteria are needed to decide whether a consultation can be done by an employee or by a third party? Similarly, can an in-house evaluator study a consultation, or should the research be left to outsiders? These questions are not so much heuristic as they are necessary to be considered before setting up consultation research studies. Directed studies on these problems (Holahan 1977; Kelman and Wolff 1976) have produced important findings, and further research will be required. However, the issues of timing and setting remain key to the successful design of a consultation research project.

Statistical Issues

A common complaint in reviews of mental health consultation research is that the statistical techniques employed tend to be unsophisticated (Alpert and Yammer 1983; Medway 1982). It could be added that innovative use of statistical procedures is difficult to identify in the literature. Multivariate analysis of variance has been accessible to most researchers since the early 1970s, but few studies have used these techniques. Three multivariate analyses represent effective use of this technique: Bagley and Larsen (1976) studied consultation training with learning disabled youngsters; Blaustein et al. (1978) analyzed a military mental health consultation project; and Mulder et al. (1983) were able to identify distinct leadership patterns operating in the practices of consultants.

Time-series and single-subject designs have received little attention in consultation research. A genuine time-series study could not be discovered in the literature to date, though several studies which tried to apply repeated measures presented themselves as time-series research. This is regrettable, since all of these statistical techniques are uniquely fit to the special research problems presented by consultation research.

Among the statistical issues appearing in the research are sample size, control and randomization, and generalization.

Sample size. Small sample size has been a particularly irksome problem in mental health consultation research. Much criticism of consultation research has been based on the way that small sample sizes are reported. For example, a study that looked at the effect of a specific training package on only three consultation programs might present its results as "successful in 67 percent of the centers studied." Decisionmakers are likely to look upon such findings as misrepresentations. Few studies have used small samples successfully or lawfully, either in execution or reporting.

Small sample size has also dictated what can be studied; thus, the characteristics of consultation participants and the content of intervention strategies have received a good deal of attention. Larger sample sizes are required to examine training process itself. For example, consultation outcome may be intimately related to such consultee characteristics as previous experience, education, and personality traits. Small samples will not allow the data manipulations required to test the effects of these characteristics. Indeed, samples have rarely been large enough to allow for homogeneous isolation of cohorts according to these characteristics.

Special consideration is merited by the sample size issue of the $N=1$ model. " $N=1$ " is a term of art; it is strictly defined, and there is a whole literature describing the conduct of single-subject studies (Azrin 1977; Hinkle et al. 1977; Meyers et al. 1979). However, using a conservative definition of single-subject or single-organism design, no truly representative study could be found in the consultation area. Many studies exist where only one program or one intervention was examined, but these resemble medical case histories more than single-organism designs. Typically, these case studies are preexperimental; their utility is reduced because their findings have been the result of something other than the intervention under observation. Their value lies in what they suggest, not in their accuracy. This chapter cannot address the proper conduct of $N=1$ studies, but their importance to consultation research cannot be overemphasized.

One approach to small sample size that can be especially recommended is the multiple baseline technique (Meyers et al. 1979). However, the researcher must be aware of the special conditions which inform these designs to avoid methodological errors.

Controls and randomization. Any study intending to demonstrate effectiveness requires controls to demonstrate what the intervention did, apart from invalidating factors. In preparation

for this chapter, approximately 100 outcome studies were reviewed; some 40 percent lacked any form of control or comparison groups. This finding is consistent with similar reviews of outcome or effectiveness studies (Mannino and Shore 1975; Medway 1979). Poorly constructed controls are equally confounding—for example, when volunteers are compared with staff, or when differences in education and experience are not accounted for in setting up comparisons.

In many studies where controls have been attempted, there are problems with randomization. The absence of randomization in the selection of experimental and control groups results in findings which must be viewed cautiously. Randomization is not always possible; in most mental health consultation settings, it is, at best, difficult. Random assignment is the *sine qua non* of true experimental design, although a study lacking randomization can have value. Such a study can achieve scientific integrity if the author clearly states the possible sources of invalidity due to design deficiencies and cautions readers about drawing unfounded conclusions (Kelly et al. 1970).

Generalization. The replication and generalization of findings suffer two forms of abuse. The one-shot study may produce effects that bear no implications beyond the specific circumstances of the particular program or intervention. The findings may be heuristic or interesting, but they add little to the knowledge base about consultation. The far more pernicious abuse is overextrapolation. At this point in the state of the art of consultation research, few valid generalizations can be made, and interpretations of findings must be conservative.

These problems and issues with mental health consultation research must be seen in perspective. Control problems will always be a part of consultation research, but more and more studies are including controls. More attention is now being focused on specific training characteristics (Knoff 1985); multilevel and multivariate assessments are also more prevalent. By building in the requirements and logistics from the beginning of the study, researchers are dealing with the replication issue and making it possible to generalize effects to similar situations or client problems. Finally, theoretical models are now so defined that useful interactive effects and correlations can be determined. Developments in statistical techniques and computer-aided statistical packages have made the analysis of such interactive effects more accurate and manageable (Joreskog and Sorbom 1978). Though tentative, mental health consultation research is producing useful information about the practice of mental health consultation.

Future Research Directions

Decreased funding and the pressing demands for direct services suggest a modest future for mental health consultation. Those familiar with its applications appreciate its place in mental health work. Regrettably, because it lacks the immediacy of primary intervention efforts, consultation is often the first program to be cut in times of fiscal austerity. Consultation advocates argue that such cuts are a false economy, given what we know about the ripple effects of consultation.

In this context, mental health consultation research has a more important role to play than ever before. Researchers will have to compete for limited funds with other mental health activities. The quality of the research proposed, combined with the potential benefits, must improve if studies are to go forward. Lack of direction has been a problem; perhaps funding pressures will help produce a unified mission statement to guide research. Rather than adding to the already lengthy list of disparate findings, studies are now needed to establish comparable findings that can be extended to other circumstances and problems. Data-based reformulations of existing theories and models would help guide both research and practice. To further ground existing concepts, there is a need for long-term followup studies on large populations. Research designs need to be creative, financially feasible, and directed toward the control of threats to internal validity. The settings for research would benefit from expansion. For example, it may be time to encourage collaborative projects making use of field, university, and business settings to collect data.

These are some very general possibilities. Based on what is already available, several specific research suggestions can be identified. The first has to do with innovative designs. The conflict between scientific rigor and administrative ease is an opportunity for the creative researcher. Practical considerations will limit procedures to some extent, but improved instrumentation and informed statistical manipulation can compensate for many naturally occurring barriers. Sophisticated but readily accessible statistical techniques can accommodate design problems: these include multivariate analyses of variance, path analysis, time-series designs, multiple baseline studies, and regression-discontinuity analyses. $N=1$ designs can produce useful results, and such designs can be especially apt for consultation research. Design issues need much attention; their purpose, now more than ever, will be to produce subtle, indepth assessments so that factors and differences which predicate outcomes can be delineated.

In terms of specific suggestions about mental health consultation research topics, the following needs can be listed:

- More focus on the specific relationships between attitudinal changes and behavioral effects;
- More focus on how the attributes of the consulting parties affect the consultation;
- Emphasis on process aspects of consultation, especially input variables;
- Studies which include assessments of attitude, behavior, and self-reports of the participants;
- Multilevel measurements (consultee, client, and system) combined with multivariate outcomes;
- Studies of community organization consultations;
- Studies which assess group, organizational, and social system variables;
- More attention directed to the specifics of consultant-consultee interactions;
- Studies on the utilization of the scientific knowledge gained through both consultation and consultation research; and
- Studies on the ethical problems presented by consultation (Gross and Robinson 1985).

Technological advances may enable a variety of new developments in consultation research. The proliferation of relatively inexpensive personal computers has made it possible to store, organize, and calculate the data from research projects. In addition, these devices can be used as teaching machines. For example, the computer can be fed a consultation training program which can both train and evaluate an individual worker; such programs are already available for empathy training, management by objective, and organizational effectiveness.

Information retrieval systems are especially well constructed to simplify the tasks of surveyors and reviewers. Access to large data bases is becoming easier and cheaper, and the interrelationships among them are improving. It is now possible to track similar topics and studies simultaneously through many systems. A seldom-used feature of this technological power is the ability to link basic research and applications. By setting up the search strategy so that practice findings are linked with conceptual or

basic research results, the retrieval activity becomes its own form of research.

Telecommunications already play an increasing role in consultation. Personal computers or sophisticated terminals in remote areas pick up consultation from centralized resource providers. A rule of thumb in using this technology is to substitute communication for transportation whenever possible. Such services as on-line consultation would allow for an efficient distribution of scarce resources. Evaluating the problems and benefits of such interventions opens a new field for researchers.

For those who make it the focus of their interests, mental health consultation research will provide a fruitful area. As they search for the issues and problems, they will discover the milestones of their predecessors. There are some shining moments and some failed pretensions. The past demonstrates that the effort is worth the pursuit; in the future, as in the past, good research will help direct the evolution of the mental health consultation field.

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members of the family.

The first of these is the *Chrysomelidae*,
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CHAPTER 16

CONSULTING WITH INFORMAL CAREGIVERS: STRENGTHENING INFORMAL HELPING AND SOCIAL SUPPORT PROCESSES

Roger E. Mitchell, Ph.D.

Introduction

Recently, residents of several California communities were exposed to radio spots, pamphlets, and billboards bearing the message that "Friends can be good medicine." Sponsored by the California Department of Mental Health, this primary prevention program was intended to increase citizens' awareness of the beneficial consequences of supportive social ties.

As interest in social support and informal helping has mushroomed, calls have increased for consultation efforts aimed at strengthening natural helping networks (Biegel et al. 1984; Gartner and Riessman 1984; Gottlieb 1983a; Whittaker and Garbarino 1983). Garbarino (1983), for example, reviewed some of the evidence linking the availability of social support with decreased vulnerability to stress, and concluded: "If we can learn anything . . . it is that any professional helper should be concerned with finding ways to complement rather than ignore or compete with informal social networks" (p. 27). Similarly, Vallance and D'Augelli (1982a) argued that "the community mental health system cannot afford the luxury of having the mental health professional be the sole--or even the primary--provider of direct services to clients An important role for the community mental health professional lies in the development of means for identifying and training natural helpers in the community" (pp. 224, 236).

This interest in the development of consultative relationships between mental health professionals and informal caregivers is likely to grow in the near future as a result of several factors, such as decreased financial support for traditional mental health services, failure of traditional mental health services to reach special populations (e.g., rural elderly), continued emphasis at both the local and Federal level on self-help-oriented efforts, and varied and growing research demonstrating links between informal support and mental health outcomes across a diverse array of populations (e.g., Barrera 1981; Bloom et al. 1982; Gottlieb 1983a;

Mitchell and Hodson in press). As Biegel et al. (1984) point out, "We are now beyond the point of arguing whether agency professionals should work with informal service providers in the community" (p. 13). Social support and informal helping networks can provide new options for dealing with psychological distress.

Clearly, expectations are increasing regarding mental health consultants' capabilities for bolstering informal helping processes. However, there is much less consensus as to the kinds of role relationships, values, and technologies that should guide the development of such consultative efforts. For example, consultants are forced to confront, implicitly or explicitly, a complicated set of issues in implementing consultation efforts involving informal caregivers.

One such issue is: How does social support actually work, and what support patterns work best? As interventions to promote natural helping proceed, there are increasingly thorny questions regarding the differential efficacy of different types and sources of support and the minimum level of intensity and duration of the intervention needed to effect change. If consultants are to shape the helping behaviors of community residents, they need a more empirically founded understanding of the potential strengths and limits of particular support patterns.

Another issue consultants must face is: What factors shape the emergence and development of supportive helping interactions among individuals, as well as within neighborhood and organizational settings? The preponderance of studies in the support/informal helping field have examined the specific helping behaviors of wide ranges of individuals, but have typically not examined the broader social context out of which such stress, coping, and support processes emerge. Although we are increasingly able to document the deleterious effects of deficits in support (e.g., Cohen and Syme 1985; Mitchell et al. 1982), there has been little study of the determinants or longitudinal development of such patterns. What are the characteristics of environments and social systems that are likely to promote informal helping or enhance the development of supportive social ties? What are the personal and environmental contexts that characterize individuals who are effective in establishing a wide repertoire of coping responses and a supportive social system and who are able to become effective helpers? What are the characteristics of neighborhoods or social settings that contain helping networks which are able to sustain themselves over time without individuals feeling "burned out" or "drained"? To the extent that the consultant pays attention to (and modifies) the individual and environmental variables that shape helping patterns over time, there will be a greater likelihood that changes in consultees' helping behaviors will be

sustained and generalized. Consultants need to draw upon basic research on social support and helping processes in order to outline more clearly some of the tradeoffs involved in the fostering of particular types of support patterns.

Programs designed to enhance informal helping activities also take place within a larger political context. Consultants need to be aware of how potential conflicts among advocates of informal helping processes can occur when differing values underlie their approaches to professional-informal caregiver collaboration. For example, complaints regarding the timidity of professionals in using their knowledge about helping to work with informal networks are mixed with warnings about the potential cooptation of natural helpers as a result of such contact. Gottlieb (1983b) suggests that the values underlying professional helping relationships are very discrepant from the norms of reciprocity, mutual reliance, long-term attachment, and consensual decisionmaking that are associated with informal helping relationships. He argues that the attempt to transmit clinical skills through mental health consultation "is an inappropriate and potentially dangerous form of collaboration with informal support systems . . . because it risks supplanting the positive social functions that arise from public participation in mutual help activities" (p. 1). In fact, Kleiman et al.'s (1976) description of the demise of a mutual-aid program for cancer patients highlights the difficulties caused when informal helpers and professional staff have contrasting expectations and values.

At a programmatic level, consultants can receive varying reactions to proposed consultation efforts because very different ideological goals and social policy values are being promoted under the general rubric of advocacy for programs of informal helping. For some people, such efforts provide an opportunity to expand the reach of the mental health system in a time of shrinking financial resources by incorporating informal helpers as an ancillary mental health resource. For a different group, they are a means of increasing empowerment among target populations, of challenging the broader assumptions and philosophy underlying the mental health service system, and restructuring it in more preventive directions. But to some critics, such approaches represent a potential (and perhaps unintended) "smokescreen" for further reductions in formal services and the shifting of responsibility of mental health care from institutional sources to individuals and communities that are already lacking in resources. Thus, consultants need to be aware of the unintended consequences of collaboration and of how conflicting social agendas may shape the political support for seemingly well-reasoned consultation efforts.

Given this background, it is the purpose of this chapter to review some of the empirical work on consultation with informal helpers thus far and to outline some of the methodological and ideological issues consultants to informal helpers are likely to face. More specifically, the goals of this chapter are: (1) to review empirical research on the effectiveness of consultation to indigenous helpers and on the factors that contribute to such effectiveness, (2) to suggest issues that researchers and practitioners should consider in developing and evaluating consultation programs with informal helpers, and (3) to suggest how an ecological orientation can broaden our frame of reference in thinking about consultation around support-oriented interventions.

In particular, it will be argued that an ecological perspective is especially useful in focusing the attention of the prospective consultant on the following questions: (1) What are the personal and environmental characteristics on which the consultant should focus so as to enhance the emergence of help-giving exchanges, as well as the maintenance and endurance of supportive, helping networks? (2) How can support-oriented consultation efforts be designed to encourage the development of prosocial behaviors, as opposed to only the prevention of pathological behaviors? (3) How can consultants minimize the broader costs and consequences of support interventions for informal caregivers, so that the potential maintenance of program effects is increased?

Consultation Efforts With Informal Helpers

Defining the Domain

Underlying most consultation efforts with informal helpers is a strong belief in the importance of informal social ties as a primary locus of help and assistance that is health-sustaining or health-compensating in the face of stress. However, the specific programs and intervention efforts based on this belief vary widely in scope, intensity, target population, and aims. For example, one program involved the use of public health nurses to do short-term grief intervention work with families who had experienced sudden infant death syndrome (SIDS) (Lowman 1979), while another implemented communication skills training for industrial foremen in an effort to increase their ability to serve as emotionally supportive, help-giving resources to the employees under their supervision (Stoudenmire et al. 1974). Along different lines, Collins (1983) provides a revealing description of her attempts to act as a consultant with Indochinese refugee groups to encourage the use of natural helpers as a means of providing greater assistance to those in need and of beginning to rebuild networks where relocation had caused social disruption.

Clearly, consultant activities can vary considerably depending upon the kind of informal helping networks they wish to influence. How does one categorize this diverse and heterogeneous array of intervention with informal helping networks? Froland et al. (1981) suggest a typology based upon type of intervention strategy (e.g., personal network, volunteer linking, mutual aid networks, neighborhood helping networks, and community empowerment) while Gottlieb (1983b) focuses on different types of helper roles (e.g., member of a mutual aid group, community caregiver, natural helper). Drawing on the latter categorization, this chapter will focus on three general consultation approaches.

The first of these approaches entails developing mutual aid networks. This involves linking people who share a common problem, interest, or background--for example, people experiencing a similar stressful life event such as illness or bereavement. Mutual-aid or self-help groups may take different approaches depending on whether their primary aim is to address specific problems or to serve as a means of organizing themselves for internal social satisfaction and collective action (e.g., Gartner and Riessman 1984; Pancoast et al. 1983; Pilisuk and Minkler 1980). Rogers et al. (1980) describe a preventive, self-help program that trained widows in working with others who had been recently bereaved. In contrast, Edmundson et al. (1982) describe a self-help approach aimed at developing some enduring ties among individuals at risk for psychiatric hospitalization.

The second general consultation approach entails developing relationships with "community gatekeepers," i.e., individuals who are in non-mental-health roles (e.g., teachers, clergy), but are nonetheless in a position of potentially being of aid to a wide segment of their community. There have been attempts to work with bartenders (Bissonnette 1977), beauticians (Wiesenfeld and Weis 1979), Cub Scout den leaders (Conter et al. 1980), elderly (Biegel et al. 1984; Haber 1983), nurses (Huessy et al. 1969), and school personnel (Asp and Garbarino 1983; Klingman and Ben-Eli 1981).

The third consultation approach involves encouraging the efforts of "neighborhood central figures" or "natural helpers," i.e., individuals in the community who are selected because they are seen by others as being an important helping resource, and not because of their assumption of any particular role (e.g., Collins 1983; Collins and Pancoast 1976; Gatz et al. 1982; Kelley et al. 1977; Vallance and D'Augelli 1982b). For example, Ehrlich et al. (1981) describe a project aimed at developing an "independent and self-perpetuating" program of helping-skills training for community residents. Gottlieb (1983b) suggests that each of these

informal helping situations presents different constraints and opportunities to the consultant.

Across each of these approaches, consultants must deal with similar issues of selection, training, etc. The diversity of these programs suggests the number of dimensions along which efforts with informal helpers can differ. There are a number of dimensions which consultants should consider in planning an intervention with informal helpers. These include the following:

- Target population. Is one interested in reaching residents of a community at large, or only those "at risk" because of exposure to some specific stressor (e.g., cancer, bereavement)? How are these latter individuals likely to be reached in informal helping interactions by the consultees?
- Type of relationship. Are the consultees expected to provide support within the context of their already existing network of relationships, or will they rely on relationships that are newly created by virtue of the helping role (e.g., as in a widow-to-widow self-help group)?
- Selection. Is the informal helper selected for involvement as a consultee on the basis of role-related status in the community (e.g., clergy), shared characteristics with the target group (e.g., also bereaved), personal qualities (e.g., interpersonal skills), or interest in becoming involved in the program? Although some researchers suggest that personal traits are central in the development of natural helpers who can provide physical and emotional resources to others without fear of being "drained" (Collins and Pancoast 1976), there has been little specification of how these qualities might be assessed.
- Training. To what extent are traditional mental health counseling/therapy relationships presented as models for the informal helper to emulate? While Gatz et al. (1982) espouse a problem-solving and resource utilization model in training elderly persons as natural helpers, Huessey et al. (1969) describe a traditional clinical model in working with public health nurses, including the assignment of the text Introduction to Dynamic Psychiatry.
- Intensity of intervention. What level of effort and commitment on the part of the consultant and the consultee is presumed necessary to achieve a minimal level of desired change in the consultee's informal helping behaviors?

- Outcomes. Is one primarily interested in the psychological adjustment of individuals over the short term as they deal with a crisis situation, or also in more long-term, positive changes in the structure and quality of the individual's social ties?
- Maintenance of change. What elements of the consultation intervention are likely to ensure that changes in consultee helping behavior are likely to be maintained over time?

Clearly, interventions with informal caregivers reflect a range of methods, goals, and ideological assumptions about the helping process. Consultants need to be clear with themselves, their collaborators, and consultees about their intended aims, as well as how the consultation effort will specifically achieve these aims.

Investigating Informal Helping Processes

In order to design ecologically valid consultation efforts with informal caregivers, Cowen (1982) suggests that the initial task is to understand naturally occurring helping processes: that is, which people with what kinds of problems use what sources of help with what kinds of outcomes. He also concludes that "a much more precise knowledge of a society's de facto help-giving mechanisms is an essential precondition for upgrading its help-giving effort" (p. 394). In fact, much of the empirical work to date on informal caregivers has involved attempts to document what informal helpers actually do when confronted with individuals who are struggling with problems or who are seemingly in distress. Investigations of informal help giving and receiving have included examinations of the actions of individuals in potentially caregiving roles (e.g., divorce lawyers, industrial foremen), as well as more ethnographic studies of community residents seen as "central figures" within their communities (e.g., Alcorn and Rennie 1980; Collins and Pancoast 1976; Cowen 1982; Cowen et al. 1979; Cowen, McKim, and Weissberg 1981; Cowen, Gesten, Davidson, and Wilson 1981; Doane and Cowen 1981; Ehrlich et al. 1981; Felner et al. 1982; Gottlieb 1978; Kaplan and Cowen 1981; Vallance and D'Augelli 1982b).

Although such studies document the fact that large numbers of individuals are involved in providing interpersonal help, they raise as many questions about the helping process as they answer. First, patterns of helping take a myriad of forms, and helping strategies may differ dramatically in the degree to which they resemble those used in therapeutic transactions. Informal helpers

are as likely to 'tell the person to "count one's blessings" or to take direct action to solve the problem as they are to offer support and sympathy. Second, there is relatively little data on the personal and environmental characteristics that shape an individual's choice of helping strategies. Although there is some discussion of how helping strategies differ across settings (Cowen 1982; Mitchell and Hurley 1981), we know little about the factors that influence the frequency and quality of informal helping. Finally, we have little empirical information regarding what informal helping strategies are the most useful in particular situations. This state of affairs is not unlike the early days of research on psychotherapy outcome: there is a conviction that something helpful is going on within these encounters with no clear consensus as to what the specific mechanisms are.

Evaluating Consultation Efforts With Informal Helpers

Have consultation efforts been successful in shaping the actions of informal helpers so as to enhance the informal helping processes in which they were involved? The following outcome criteria were used to evaluate the degree to which intervention efforts had an impact on any of several aspects of the consultees' helping behavior. These variables include several aspects of the helping process: (1) helping style, (2) frequency and duration of helping activities, (3) subjective experience of the helper, (4) diversity of helping recipients, (5) relationships with other network members who might serve as caregivers, and (6) generalization of change over time and across settings. Few consultation efforts with informal caregivers have attempted to collect empirical data documenting the consultation's effects on their consultees (see table 1 for a listing of some of these). Since different consultation efforts may be intended to produce different outcomes, studies have not tended to collect data along the whole range of outcome criteria listed. Nonetheless, one can see a number of important implications for designing consultation intervention and research efforts from an examination of these data.

Helping style. Were there changes in the style or manner in which the consultees dealt with individuals seeking help? Consultation efforts have been most concerned with changes in helping style and have generally been able to report some positive results (e.g., Conter et al. 1980; Ehrlich et al. 1981; Leutz 1976; Taynor et al. 1976). Wiesenfeld and Weis (1979), for example, implemented a consultation program for hairdressers which stressed "the strategies of empathic listening, reflecting clients' feelings and presenting behavioral alternatives" (p. 789). Such a program seems geared toward taking advantage of accumulated knowledge of behaviors that are helpful in "therapeutic" and counseling transactions. Such approaches are not unanimously encouraged

Table 1. Interventions aimed at informal helping behavior

| Authors | Consultees | Program | Control group? | Results |
|------------------------------|---|---|----------------|---|
| Conter et al. (1980) | Cub Scouts den leaders (N=12) | 7 weekly 2-hr groups | no | Significant pre-post change in verbal helping interactions, but which failed to persist at followup |
| D'Augelli and Ehrlich (1982) | Self-selected community residents (N=37) | 16-18 hrs training in helping skills | no | No significant pre-post difference in patterns of helping with regard to frequency, duration, type of problem, or type of helping responses |
| Ehrlich et al. (1981) | Self-selected community residents (N=76) | 16-26 hrs training in helping skills | no | Changes in participants' verbal helping skills, as assessed by ratings of taped role-playing interactions |
| Gatz et al. (1982) | Elderly natural helpers (N=22) | 2-day workshop and weekly sessions on problem-solving skills and use of community resources | no | Increased levels of life satisfaction and knowledge of community resources; no changes in problem-solving style |
| Kelley et al. (1977) | Natural helpers (N=31) | 24 training sessions on nondirective counseling techniques | no | Increased communication skill and confidence in helping abilities |
| Leutz (1976) | Clergy, social club owners, merchants, spiritualists (N=29) | Information re: substance abuse provided during weekly visits | no | Increased number of referrals to formal programs |

Table 1. Interventions aimed at informal helping behavior (Cont.)

| Authors | Consultees | Program | Control group? | Results |
|----------------------------|---------------------------------|--|----------------|---|
| Stoudenmire et al. (1974) | Industrial foremen (N=21) | 10 weekly 1-hr sessions on emotional problems, interpersonal relationships, communication skills | no | Increased comfort in helping role and self-perceptions of increased effectiveness |
| Taynor et al. (1976) | Community agency workers (N=16) | 4 weekly 2-hr sessions on family interaction and family intervention | yes | Greater change in confidence in helping skills, and in willingness to intervene shown by experimental group |
| Wiesenfeld and Weis (1979) | Hairdressers (N=13) | 10 1/2-hr weekly sessions on helping skills and resource networks | yes | More pre-post change toward the helping strategies of reflective feelings shown by experimental group |

though. Collins and Pancoast (1976) warn against "professionalizing" informal helpers and argue that natural neighbors' "style should be supported but in no way altered by training or supervision" (p. 76).

Frequency/duration of helping activities. Were there changes in the amount of helping that occurred, in terms of either the number of people helped, the frequency of helping contacts, or the duration of these contacts? Since many consultants implicitly have such changes in mind as desired goals of their consultation efforts (e.g., Gatz et al. 1982; Leutz 1976), postintervention assessments of helping frequency are crucial. To examine changes in consultees' helping patterns, Ehrlich and D'Augelli (1982) had individuals complete descriptions of each helping conversation occurring during 1-week periods preceding and following training. No significant changes were seen in the number of people helped or in the frequency or duration of helping contacts, although there was greater reported use of positive helping strategies. The authors did not see this as problematic since their primary objective was to change helping style: "Indeed, it may provide some reassurance the training did not adversely alter helping network characteristics while the training did in fact enhance helping skills" (D'Augelli and Erlich 1982, p. 455). This finding suggests the importance of long-term followup to investigate what kinds of changes persist as consultees begin to implement skills, as well as the need to be specific in outlining the kinds of changes one hopes to produce.

Subjective experience. Were there changes in the indigenous helpers' perception of their helping role or in their degree of comfort and satisfaction in assuming such roles? Most programs reported that the informal helpers showed increased confidence as a result of their training experience. For example, Taynor et al. (1976) stated that "group members perceived themselves as having more skill, greater confidence, [and] a higher likelihood to intervene" (p. 16). As Ehrlich et al. (1981) caution, however, such perceived changes in skill level may not necessarily be accompanied by changes in behavior. Although one group of informal helpers showed no significant differences in behavioral measures of verbal helping skills as a result of training, they nonetheless "perceived themselves as being significantly more helpful, were more satisfied with their helping style, and viewed themselves as better listeners" (Ehrlich et al. 1981). Thus, projects aimed at introducing behavioral changes in consultee helping style will need to go beyond such self-report data to demonstrate their effectiveness. In addition, if consultation efforts have the potential of significantly increasing the consultees' subjective sense of competence, they should also make sure that caregivers have a realistic appraisal of their own helping capabilities and the limits of their

helping roles. Informal helpers may put themselves at greater risk for disillusionment and burnout if they expect too much of themselves in individual helping interactions or "drain" themselves by assuming more nonreciprocal helping relationships than they have the personal resources to handle.

Diversity of helping recipients. Were there changes in the types of individuals who were provided assistance? Since some programs are specifically concerned with eventually increasing the informal support available to special, "at-risk" subgroups (e.g., isolated families at risk for child abuse), it is important to examine the degree to which consultees are more or less likely to provide assistance to such individuals as a result of the consultation intervention. In particular, were individuals who were under high stress (and presumably in greater need of support) any more likely to be offered help? Surprisingly, there has been no examination of the degree to which the type of person that is helped changes as a result of intervention efforts. This is an important element to assess since isolated and "high-risk" individuals are often least able to avail themselves of formal or informal aid, and may be most difficult to engage. For example, Pancoast (1980) discusses the prospects of consulting with neighborhood "central figures" to enlist them in supporting "at-risk" families as a way of preventing or reducing child abuse. She notes that: "The factors that contribute to the family's isolation--geographical distance, unsociable behavior, divergent values or life-style and so forth--may make it difficult for natural helpers to reach out to them" (p. 121). Consultation programs may need to design specific strategies for consultees to reach out to "at-risk" subgroups if that is an important outcome.

A second related issue is that "at-risk" individuals may have few resources for engaging in reciprocal helping exchanges. So, to the extent that informal helpers alter their network to include large proportions of such individuals, they may be putting themselves in a position of potential "emotional drain." If the existence of a stable and supportive network for neighborhood helpers is the key to their maintaining a helping role over time, then there may be limits to the number of highly depleted relationships helpers can take on before their long-term ability to help is diminished. The degree of reciprocity in relationships may be a key variable in determining long-term stability of ties (Brownell and Shumaker 1984).

Relationships with other network members. Were there changes in the manner in which caregivers related to the broader informal network? In particular, did the caregivers have an impact on the help-giving roles of others in the networks of which they were a part? Although some investigators have aimed at

changing helping skills and style rather than altering helpers' normal patterns of relating to their broader network, it may be important for consultants to consider how they are influencing helping within the network as a whole. For example, a consultant to informal caregivers dealing with runaway youth might focus on helping the caregivers strengthen the norms for helping among their network as a whole, rather than in encouraging increased individual and solitary efforts by the existing caregivers. This might result in a greater capacity for helping in the system as a whole and reduce the likelihood that the focal informal caregivers would become overburdened and experience "burn out." Although considerable intervention effort may be involved in ensuring the diffusion of helping skills (see Ehrlich et al. 1981), such systemic changes may have more far-reaching impact.

Generalization and maintenance of change. Did changes in consultee behavior generalize across settings and persist over time? The few examinations of the generalization of consultee helping behavior highlight the importance of carefully examining the maintenance of change. For example, Conter et al. (1980) designed a 7-week training program for Cub Scout den leaders that focused on the more effective use of listening skills, limit setting, and reinforcement. Ratings of audio tapes during the program revealed that these consultees had become more proficient in the use of these behaviors, but a 1-month followup showed that the increased use of these responses did not persist after the training program had ended. Reasons for the failure of such maintenance were unclear. Conter et al. (1980) stress that "the limited generalization and lack of maintenance of the trained skills indicates that comprehensive evaluations of training programs for community caretakers must also evaluate the use of trained skills in the natural environment and their persistence over time" (p. 85). As will be suggested later, an ecological perspective can be useful in directing our focus toward the elements of the social context that sustain helping behaviors.

Designing Consultation Efforts With Informal Helpers

How does one design consultation programs aimed at informal caregivers in the absence of a substantial body of applied research that examines either the efficacy of varied informal caregiving patterns or the differential impact of intervention strategies in changing such patterns? In part, development of consultation strategies can be enhanced through consideration of findings from the growing body of basic research in social support (e.g., Brownell and Shumaker 1984). This research raises a number of questions that highlight the complexity of informal helping and support

processes. As indicated below, the success of a particular consultation strategy may vary considerably depending upon the population being targeted, the type and source of support being provided, and the particular outcome that is expected to be achieved. Drawing from the broader social support literature, I suggest several issues that the consultant should address before initiating consultation efforts with informal caregivers:

Are there individual differences in individuals' need for and ability to benefit from support that would compel program planners to alter and vary the nature of their consultative strategies? In particular, do the characteristics of people that make them vulnerable to psychological disorder in the face of stress (e.g., poor coping skills, social isolation) also make it more difficult to engage them in a consultation effort and less likely they will take advantage of support that is offered? Gottlieb (1983a) describes programs aimed at bolstering support available to parents of premature infants (Minde et al. 1980) and to bereaved women (Vachon et al. 1980) and notes that the dropouts and low attenders tended to be those with more severe psychological problems and greater social isolation. Social competence characteristics that affect one's ability to develop a supportive network in the first place may also affect one's ability to feel comfortable in and to utilize informal support groups. Special efforts may need to be made if informal helping efforts are to engage individuals with histories of social isolation or of problematic interpersonal relationships since these individuals may be most in need of assistance.

Thus, different consultation strategies may be called for depending upon whether one is interested in increasing the helping behaviors available to: (1) self-selected community residents, the majority of whom would presumably show moderate levels of social competence; or (2) particular groups who are at "high risk" because of deficiencies in their abilities to develop or utilize social ties. In developing a program for individuals at risk for prolonged institutionalization, for example, Edmundson et al. (1982) emphasized the development of interpersonal problem-solving skills, as well as the growth of peer support networks. Mere proximity to potential supporters is not likely to be actualized into support if the individual lacks the skills to develop and nurture reciprocal ties (D'Augelli 1983).

What are the specific personal characteristics to which consultants should pay attention in trying to tailor their intervention to the needs of the population under consideration? To date, the links between support and a variety of dispositional variables have been examined: competence (Dean and Ensel 1982; Husaini et al. 1982); hardiness (Ganellen and Blaney 1984); and locus of control

(Riley and Eckenrode 1984; Sandler and Lakey 1982). Although the findings have been inconclusive thus far, there is some evidence that social support has a greater effect in moderating the impact of stress among individuals with higher levels of personal resources (Sandler and Lakey 1982; Riley and Eckenrode 1984). For example, one study of 314 low-income mothers involved assessments of both personal resources (i.e., educational level, family income, health locus of control, and beliefs about the efficacy of seeking help) and mobilized social support (i.e., the average number of informal ties that had been helpful to the respondent in coping with stressful events) (Riley and Eckenrode 1984). They found that support mobilization was related to lower negative affect scores for those in the high, but not the low, personal resource groups. Individuals with high personal resources may be more effective at mobilizing support from the individuals they approach because of better coping skills in eliciting support or because they present less of a threat of "draining" the potential helper in the process of being helped. Thus, consultants need to consider the help-utilizing competence of those intended to be the ultimate beneficiary of the support-oriented intervention.

Does the effectiveness of informal helping in promoting health and protecting individuals from stress vary as a function of the type of support or the source of the support? This question forces us to confront our basic assumptions about how support has its effects. Is the health-promoting effect of helping processes due to the fact that a diverse array of helping behaviors communicate a similar basic message that one is cared for and valued? Or, do different types of supportive actions have differential efficacy? Although most early research on social support viewed it as a unidimensional and global entity, more recent work has devised more detailed categorizations of supportive functions. These range from distinctions between emotional and instrumental support to more elaborate schemata involving emotional, instrumental, informational, appraisal, companionship, and advocacy support (e.g., Barrera and Ainlay 1983; Caplan 1974; Gottlieb 1978; Mitchell and Trickett 1980; Weiss 1974).

Cohen and McKay (1984) speculate that only those interpersonal relationships that provide the appropriate forms of support will prove to be effective in protecting the person from the adverse effects of stress. They suggest that the appropriateness of a particular type of support depends upon its relevance to the coping tasks demanded by the stressors the individual is currently facing. For example, Moos (1982) describes the tasks that must be dealt with in coping with acute health crises. An individual with a debilitating illness must deal with the conflict between seeking support and avoiding falling into a "passive-dependent" patient role. Providing companionship that assists the individual

in maintaining regular routines may be as important in bolstering the individual's optimism and sense of self-competence as "emotionally supportive" discussions that focus solely on aspects of the sickness.

For those consultation efforts whose ultimate aim is to bolster the degree of support available to those experiencing specific stressors (e.g., bereavement, unemployment, illness), it may be particularly important to outline the specific supportive behaviors that are expected to result in specific outcomes. Training for the informal helpers serving as consultees should try to promote understanding of the developmental tasks faced by those experiencing a specific stressor, and then highlight the use of the appropriate helping strategies. In cases where the goal is to provide support to sustain health rather than cope with a crisis, it is unclear whether and how specific types of support may have varying effects.

In addition, the source of support can be an important factor moderating support effectiveness. In one study, for example, cancer patients reported the provision of information and advice as helpful when coming from medical care providers (especially when provided in an emotionally supportive context), but not when provided by family and friends (Dunkel-Schetter 1984). These cancer patients seemed to resent attempts by nonexperts to advise them on how to "recover quicker or how to cope." In a study of women dealing with bereavement, Bankoff (1983) also found that the source of support made a difference, although this was moderated by the phase of bereavement with which they were dealing. For women in early stages of bereavement, support from family members had a positive impact on well-being. In contrast, support from a much wider range of sources (i.e., widowed friends, neighbors) was salient in a later transition phase when women were faced with the task of reorganizing their lives as single persons. Thus, consultants need to shape their selection of consultees and their training programs to see that support is provided that will be seen as appropriate by those receiving the help.

Is the effectiveness of support interventions likely to vary as a result of the outcome criteria being examined? In assessing the impact of social support upon personal functioning, most of the studies in the support field have used global measures of psychopathology, such as depression, anxiety, and general well-being (Mitchell et al. 1982). Inclusion of a wider range of indices could help to pinpoint more precisely the processes through which support influences health and to demonstrate the positive impact of informal helping processes on a wide range of prosocial behaviors.

Examination of a wider range of outcomes may help us assess the value of supportive interventions beyond an immediate impact upon psychopathology. For example, two programs aimed at bolstering support for new parents found little impact on global measures of health status and well-being, although there was some evidence of increased comfort in discussing child-rearing concerns with members of their own network (McGuire and Gottlieb 1979; Wandersman et al. 1980). Such changes might have long-term beneficial effects by making parents more at ease about seeking help for future parenting concerns. Such ties may also make it easier for network members to intervene spontaneously to provide assistance and role modeling concerning child rearing. Thus, supportive behaviors can promote specific practices that may enhance the well-being of other members of the network or enhance the long-term well-being of the recipients.

Toward a Broader Conceptual Framework

This surge of interest in social support and informal helping processes is likely to produce increasing amounts of research which will enrich and significantly shape the direction of support-oriented consultation efforts. However, there are several conceptual biases in this literature that limit its utility for the design of such interventions. There has been a failure to go beyond examination of helping processes at the dyadic level and to focus on broader systemic issues regarding support interventions. For example: How does the environmental context shape the development and continued utilization of informal helping processes? What are the broader costs and consequences to those in the social network (especially the caregiver) of the adoption of particular helping patterns? Sensitivity to such issues is likely to enhance the consultant's ability to design programs that are successful in introducing and maintaining changes in consultees' helping behaviors.

A social-ecological perspective can help redirect the focus of our thinking regarding informal helping processes in useful ways. First, within such a perspective, persons and environments are seen as interdependent resources that create varied conditions for the expression of social support (Trickett et al. 1985). The consultant is reminded that the task is one of trying to understand how personal, environmental, and situational factors operate together to influence the help-seeking/help-giving and coping strategies that are chosen by individuals (Mitchell and Hodson 1983), as well as the patterns of social support and coping strategies that emerge within groups or organizations. Second, a social-ecological perspective emphasizes adaptation and change over time, thereby directing attention to how support and coping

repertoires are "expressed, elaborated, and sustained" over the life of both the individual and the system of which he or she is a part (Kelly 1977). One becomes oriented toward examining the broader short- and long-term consequences of particular support patterns. Given this background, the following pages will address several questions that are seen as crucial for the design of such consultation efforts.

What are the personal and environmental characteristics that contribute to the emergence of help-giving exchanges, as well as to the maintenance and endurance of supportive, helping networks? In addition to having evidence that social support has beneficial effects, the consultant must also have some conceptual model of the factors that influence the development of informal helping patterns. Beliefs and assumptions about how supportive ties develop will significantly shape the consultant's intervention efforts. For example, a consultant operating from an "individual" model might focus on the informal helper's attitudes toward the helping role and helping skills, while a "systems-oriented" consultant might focus on the structure of the helpers network ties to others.

To date, efforts to understand the helping process (both in terms of the effectiveness of natural helpers as well as the ability of those under stress to elicit support) have focused largely on the traits and characteristics of these individuals. For example, it has been presumed that the help-seeking behaviors and social skills of recipients influence the likelihood of their obtaining support (Coyne 1976), since deficits in such dispositional characteristics as personal competence and internal locus of control have been associated with decreased support (Eckenrode 1983; Riley and Eckenrode 1984; Sandler and Lakey 1982; Sarason et al. 1983). Similarly, descriptions of natural helpers and informal caregivers have also tended to emphasize dispositional characteristics (Collins and Pancoast 1976).

As experience with indigenous paraprofessionals has shown, a focus primarily on the dyadic helper-helpee relationship can obscure the influence of the larger environmental system within which these relationships develop (Mitchell and Hurley 1981). The activities of helpers are shaped not only by their personal dispositions, but also by the structure and prevailing norms of their immediate social setting. For example, Burke and Weir (1978) examined the relationship between organizational climates and informal helping processes among employees. They concluded that informal helping was less likely to be seen as a legitimate and valued activity in organizations which did not have a participative/consultative climate. An awareness of the environmental context provides the consultant with a better understanding of the

constraints surrounding the helping process and the likely barriers or constraints to intervention. It then becomes possible to design interventions aimed not only at individuals' helping skills, but also at the ecology that shaped the development and use of such skills.

For consultants interested in influencing natural helping networks in the community, differences in neighborhood context have important implications for the patterns of helping that occur and for the interventions that attempt to influence these helping processes. For example, Warren (1980, 1981) suggests examination of a neighborhood's profile on several social-structural characteristics: identity (a feeling of belongingness to the neighborhood community), interaction (frequency and types of contacts among neighbors), and linkage (associations and contacts with individuals and groups outside the immediate local neighborhood).

Neighborhoods with differing profiles present different sets of problems and opportunities for strengthening informal help seeking and help giving. For example, the parochial neighborhood (high identity, high interaction, low linkage) is one in which there is a strong sense of neighborhood identity and contact, but much less contact with institutional and community life outside the neighborhood. The consultant is likely to find a neighborhood with numerous "central figures" and an active informal helping community. Persons in need of help or exhibiting deviant behavior are likely to be recognized and dealt with, although the resources and some of the values of the larger community may be ignored in the process. The consultant must deal with resistance to "outsiders" in such neighborhoods, but has the advantage of an already existing network whose access to communitywide resources can be promoted. In contrast, the diffuse neighborhood (high identity, low interaction, low linkage) "tends to provide a rather homogeneous setting (for example, subdivision in suburban areas or public housing projects in urban locations)" in which individuals share a sense of community identity, but do not focus their networks around their neighborhoods (Warren 1980, pp. 75-76). Networks within these neighborhoods are likely to be limited, so that those persons potentially capable of being "natural neighbors" have a more difficult time of creating links to those in need, as well as to other neighborhood residents who may be potential resources. The consultant might need to have a different set of expectations regarding the time and effort required to assist "natural neighbors" in reaching out to particularly "at-risk" populations (e.g., isolated, abusive families). Thus, the neighborhood setting, both in its values and social participation patterns, facilitates and constrains natural helping networks in ways that the change agent must understand.

Finally, an ecological perspective might lead us to ask more basic questions regarding the development of help-giving and help-seeking behaviors: How do settings socialize individuals to regard the utilization of help seeking in times of stress? How do settings influence the acquisition and use of skills that are central to the development and use of supportive social ties? For example, the learning environment in schools has been found to influence social as well as academic outcomes. Elementary students taught with cooperative rather than individualistic instructional strategies developed more positive attitudes towards those of a different ethnic background (Johnson and Johnson 1979). Such techniques have even been found to change elementary students' friendship patterns so that they become more ethnically heterogeneous (Ziegler 1981). Consultants may eventually try to influence the quality of informal helping indirectly by attending to how social systems influence the development of individuals' skills to construct and take advantage of supportive ties.

What is the impact of social support interventions on prosocial behaviors? Consultation efforts with informal caregivers have largely been concerned with how increases in helping behaviors might have an impact upon traditional mental health outcomes (e.g., depression, psychological maladjustment, etc.). One neglected area has been the concern with how informal helping processes (and interventions into such processes) might contribute to the development of prosocial behaviors. For example, if we think of social ties as a resource that needs to be sustained and renewed, what consequences do particular support interventions have for: (1) the person's ability to develop, sustain, and seek help from his or her social network in the future (Hirsch 1981); and (2) the social system's continued viability to serve as a place where reciprocal help giving is emphasized as a value and modeled as an activity?

One study of college students looked at the personality concomitants of social support, particularly with regard to attitudes toward mental illness and deviant behavior (Sarason and Sarason 1982). The results suggested that "people who see themselves as having few supportive figures in their environment and who are not satisfied with the supports they have are likely to be less tolerant of behavioral deviation by others, less likely to see friends and community as positive influences, and less optimistic about people's prospects for change" (p. 341). Although the causal direction of these relationships is unclear, it is intriguing to consider how the ability to elicit and receive support may influence one's level of altruism toward others. If the degree of social support influences one's level of concern with others, then the community should have a stake in seeing that informal helping processes are enhanced and maintained. Thus, consultants should

be attentive to how their interventions promote the help-giving and help-seeking competencies of the persons helped as well as the extent to which psychological distress is reduced.

What are the broader costs and consequences of support-oriented interventions? What is the impact of helping on the caregiver, and do women bear the brunt of this burden? Consultation interventions are likely to have limited success if their unintended consequence is to create as much stress for the caregiver as they alleviate for the intended recipient of the helping effort. An ecological paradigm highlights the importance of examining the effects of support and help-giving exchanges for both the recipient, the provider, and the help-giving system of which they are a part. Involvement in social ties entails costs and obligations as well as rewards, so that one must assess the capacity of the helping system to sustain itself over time.

Although service providers encourage family members to play a greater role in providing support to such groups as elderly dependent relatives and deinstitutionalized mental patients, there can be considerable stress associated with assuming these caregiving roles (e.g., Hatfield 1978; Hooyman 1983). Such strains should not be glossed over. In a study of social interaction and life satisfaction among elderly women, negative social experiences with others detracted from psychological well-being more than positive experiences enhanced well-being (Rook 1984). Similarly, contacts with network members that were upsetting (because of either negative input or their failure to meet needs) were more powerful than helpful contacts in predicting depression among caregivers to a spouse with Alzheimer's disease (Fiore et al. 1983). Thus, if we adopt an approach that advocates increased emphasis on informal helping processes as a way of dealing with social problems, we must make sure that the resources are in place to help sustain informal helpers. It is as crucial for the consultant to understand how to minimize the costs associated with the assumption of a helping role as it is to mobilize the helping process itself.

To date, there has been relatively little research on the factors that serve to alleviate or exacerbate the stressfulness of a caregiving or caretaking role. However, the work of Eckenrode and his colleagues (Eckenrode and Gore 1981; Riley and Eckenrode 1984) suggests that asking people to involve themselves in helping networks may be destructive to the caregivers' well-being if they already are under stress and lack the resources to sustain such helping efforts. In the study described earlier, Riley and Eckenrode (1984) examined the impact on psychological well-being of undesirable life change events happening to members of the respondents' network as well as of events that were directly

experienced by the respondent. They found that as the level of stress experienced by network members increased beyond a moderate level, so did these women's ratings of the average level of distress they personally experienced from each event. Strikingly, the strength of this relationship varied depending upon the level of personal resources available to these women: increases in numbers of events happening to family and friends were likely to have a much more devastating effect on morale among women who had less education, lower income, external locus of control, and negative beliefs about the efficacy of interpersonal helping. These women were clearly sensitive and vulnerable to levels of undesirable life changes happening within their networks as a whole, especially if they lacked personal resources. The authors speculate that "a stressful event to an important other is more distressing when helping the other is problematic, due to a lack of material or psychological resources with which to respond" (p. 33).

Thus, the consultant needs to assess whether the levels of stressors and resources exhibited by potential caregivers and the network of which they are a part are adequate to support them in a caregiving role. We need to be concerned not only with increases in the frequency of informal helping processes, but also with the degree to which informal helping demands are equitably distributed across groups and individuals who may be most able to assume such roles.

Addressing the question of gender and informal caregiving, there is some evidence suggesting that the demands for emotional caregiving seen at the root of much informal helping have not been distributed equitably. Belle (1982) suggests that the burden of caregiving in our society falls predominantly on women, who are typically responsible for providing support for young children, for children and adults with physical and emotional handicaps, and for aged and dependent parents. In such cases, women may become involved in increasing numbers of nonreciprocal and stressful relationships. In fact, life events may have more adverse effects on women than men precisely because women have greater involvement in caretaking activities among those in the network.

For example, Kessler and his colleagues found that women surveyed were more likely than men to report exposure to events experienced by significant others (perhaps because they consider a larger number of people "someone important"), as well as more likely to be engaged in help-giving activities (Kessler et al. 1983; Kessler and McLeod 1984). "Women cast a wide net in their concern and so are emotionally affected not only by the well-being of their immediate family and most intimate friends, but also by those to whom they are less intimately tied" (p. 19). Thus, women

are more vulnerable than men to levels of stress and crisis in their broader social networks, to the extent that a large proportion of the gender difference in psychological distress may be explained by such relationships. If caregiving efforts are to be sustained over time without the breakdown of the caregiving system, program planners must be careful not to be making additional helping demands primarily on those whose help-giving activities are already consistently extracting considerably more cost than gain.

What are the consequences for the mental health service system and society at large of different patterns of collaboration between professional and informal caregivers? Much has been written regarding the considerable differences between the "cultures of helping" of formal and informal caregivers, and the need to be alert to potential negative or unintended consequences of such collaboration on helping individuals (e.g., cooptation of informal helpers). At a social policy level, the task of assessing the impact of support-oriented consultation programs on the formal and informal caregiving systems as a whole becomes even more complex. How do shifts toward self-help alter the overall availability of assistance for particular subgroups? As consultation efforts to informal caregivers are increasingly mentioned as models for how deficiencies in the formal service systems can be addressed, it becomes important to examine the systems impact of different patterns of collaboration between formal and informal caregivers.

The potential benefits of collaboration between informal and formal helping systems could be considerable for both helping networks. The quality of professional services might be enhanced as "laypeople become intrinsically involved with giving service, as distinguished from sitting on the boards or advisory committees of agencies," while at the same time, "professionals and their agencies [might] challenge the self-help mutual aid groups to develop different styles and approaches, to be less parochial, to reach out to the masses of people in need who are not now attracted to the particular self-help group and the mode it offers" (Gartner and Riessman 1984, p. 246). Similarly, Froland et al. (1983) discuss a number of complex philosophical, institutional, and political considerations that surround the efforts at integrating formal and informal helping processes. A few of these issues are cited here:

- Is informal helping seen as a substitute for formal services or as a supplement?
- What assumptions are made about the capacity of natural support systems for self-help, and how is the burden of care distributed?

- Will the general welfare of some groups and not others be increased? What does this imply about various groups' access to resources?
- To what extent will advocacy for self-help, informal help, volunteerism, and the like be traded off against other social rights in the political arena (such as the right to equal access to services)?
- To what extent might the development of a greater emphasis on self-help promote either greater factionalism or greater pluralism at the local level?
- Would more systematic attention to the relationship between informal care and formal services actually result in cost savings?

It is important, then, that consultants try to understand how advocacy for different forms of informal helping (and for different forms of collaboration) as a social policy can be done in ways that serve to increase the total availability of assistance and avoid the disenfranchisement of particular groups.

Conclusion

The scope of consultation efforts with informal helpers is growing considerably, in keeping with the degree to which the provision of informal aid and assistance is an integral and important part of our daily lives. Unfortunately, the empirical research has not kept pace with our interest in strengthening such processes and with our beliefs in the positive benefits of these interventions. Although we can conclude that consultation does have an effect in changing the helping style of informal helpers, we are less confident of the degree to which such changes generalize across settings and are maintained over time. We are even less clear as to whether the effectiveness of informal caregivers' helping strategies may vary depending upon the characteristics of the problem and of the persons helped, and how consultation efforts should vary accordingly.

In terms of future directions, an encouraging trend is the increasing sophistication of research on social support. This work should provide information regarding the effects of a range of naturally occurring supportive transactions on varied aspects of well-being, and encourage researchers to delineate more specifically the populations to be reached, the specific outcomes to be achieved, and the specific processes through which this is likely to be achieved. In addition, the application of an ecological

perspective highlights several additional questions that may influence future growth by increasing our ability to design effective interventions: How do persons and settings interact to create varied opportunities for the development of informal helping patterns? How do they influence the development of expectations regarding the utilization of support? What are the costs and consequences for informal helpers and their social networks of adopting varied helping roles and of engaging in varied forms of collaboration with professionals? Such questions reflect considerable degrees of complexity. However, this may reassure us that our sophistication in conceptualizing consultation efforts with informal helpers is beginning to match the complexity that exists in the real world. As we continue to conduct research in the community on such questions, we should increase our effectiveness as advocates for programs strengthening natural helping systems.

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CHAPTER 17

THE THEMES, PROMISE, AND CHALLENGES OF MENTAL HEALTH CONSULTATION

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As Mannino and Shore state in the Introduction, this Handbook is intended to serve as a comprehensive overview of the mental health consultation field to date. The preceding chapters outlined the evolution of mental health consultation, both as an intervention approach and as a professional role. We have attempted to indicate how far the field has come since its beginnings in the mental hygiene movement, as well as how far the field has yet to develop if it is to fulfill its considerable promise. The field's historical development has been shown to be marked by ever-increasing growth and diversification. Further, it is clear that the field of mental health consultation is continuing to evolve; that knowledge is being generated across a wide variety of areas; that specialization is occurring; and that the general level of activity in the field is not only high but increasing. The future of the field depends, in part, on further development of a definitional, theoretical, and empirical foundation on which the continued practice of mental health consultation can be built.

The purpose of this concluding chapter is to distill overarching and recurrent themes raised by the various authors, to discuss the current status and future possibilities for the field as reflected in those themes, and to highlight some of the gaps in the field which merit close attention. In so doing, we hope to aid in building a foundation for further work in this exciting area.

Overarching Themes

At least four overarching themes are suggested by recurrent observations made by several of the authors of the preceding chapters. They address critical areas which reflect how the field has evolved and how it may evolve in the future:

- Consultation is a field embedded in larger societal issues and shifts in professional concerns which constrain its options and influence its agenda.

It is clear from the preceding chapters that mental health consultation reflects and responds to the larger social zeitgeist and shifting professional interests. While

the origins of the field and its orienting interests were linked to preventive and social enhancement goals through "indirect" service, today mental health consultation increasingly is seen as a combination of direct and indirect service, more individual than system oriented. This change is taking place in the context of larger social and professional issues. The current economic retrenchment in the broader society is being reflected by shifts in the mental health field toward individual and, indeed, biological explanations for behavior. The renewed ramifications of the medical model and the remedicalization of psychiatry are reflected in the emerging interest in health psychology. In a sense, mental health consultation is in a state of transition from those goals which spurred its rebirth as a professional activity in the 1960s to pluralistic goals and diverse forms more adaptive to the current and distinctly different social context.

On the one hand, one may view these broader social trends as challenging the very concept of mental health consultation and its viability as a professional activity. However, while the goals and strategies of mental health consultation may be shifting in response to its larger social and professional context, this Handbook also clarifies that mental health consultation is gathering, rather than losing, momentum.

Signs of this increasingly high level of activity include the large number of recently published books and monographs which can serve as intellectual exemplars for the field (e.g., Bergan 1977; Meyers et al. 1979; Gallessich 1982; O'Neill and Trickett 1982; Cooper and Hodges 1983) and the continuing development of a substantive knowledge base on which consultation practice rests, as evidenced by the extensive annotated bibliography included in this Handbook. Further, even in the face of a variety of social forces refocusing on the individual, several models of consultation—particularly those involving organizational development, process consultation, and behavioral approaches—increasingly stress the fundamental value of understanding the power of the social context in shaping both the problem and the intervention strategies designed to deal with the problem. Thus, just as consultation practice is clearly embedded in a broader social context which helps shape its interests and issues, so too the models of consultation increasingly emphasize the power of the social context in which consultation occurs and by which consultation is shaped.

- There is an elusive relationship between mental health consultation and prevention.

One specific area of debate within the field involves the degree to which mental health consultation should be viewed primarily as a preventive intervention. While much of the early history of mental health consultation was driven by a concern for the prevention of distressing conditions and the enhancement of positive development in persons and settings, its more recent history suggests that two somewhat divergent approaches to mental health consultation are occurring simultaneously. The first is the more traditional, one-to-one, professional-to-professional, medical model approach in which both the substantive expertise and the professional role are closely linked to the traditions of the specific disciplines. Consultation-liaison psychiatry serves as the prototypic example, although this is apparent in the other mental health disciplines also. While this discipline-based approach can carry strong implications for consultation as a preventive activity, neither the basic concept nor the ultimate outcome of the consultation intervention necessarily view consultation as a fundamentally preventive intervention. Indeed, varying definitions of consultation are currently being adopted which stress secondary or tertiary prevention as the principal goal of consultative activity.

The second general approach to consultation which is emerging in the current literature views consultation as a distinctive role with preventive intent. It is likely to be interdisciplinary in orientation; indeed, the specific discipline of the consultant is not always evident. Moreover, this approach to mental health consultation is designed to have systemic impact, occurs over an extended time period, is driven by ecological models, and defines consultation as a collaborative process with varied members of the host environment.

In practice, these two general approaches to mental health consultation currently overlap and may, in time, complement each other. Indeed, one may assert that it is the very ability of consultation to be of use across different goals and levels of analysis which makes it such a resilient professional activity. Still, at their core, these two approaches signal fundamentally different implicit, if not explicit, paradigms about both the goals of consultation and the roles of consultants. Those chapters describing consultation in the four basic mental health disciplines suggest how difficult it is to create genuinely distinct roles which build upon but are not captured by the

assumptions of the traditional professional disciplines. Mental health consultation should embrace varied forms as it evolves, and these forms must acknowledge disciplinary competencies and role sanctions supported by the broader culture. Special care, however, needs to be given to the development of ideas and roles which link more closely the preventive promise of consultation with its ongoing evolution. This tension appears to be alive in the field of mental health consultation, although its outcome is far from clear.

For consultation to evolve into a preventive activity, it necessitates attention to the expansion or redefinition of professional roles and a willingness to engage in interdisciplinary relationships and task-related partnerships across professional and nonprofessional lines. It also requires a clear and explicit value orientation toward resources, power, and the multiple goals of human and institutional development, as well as a knowledge base stemming from longitudinal research on the intervention process.

- Is mental health consultation evolving as a primary professional identity?

A third theme involves the degree to which consultation represents an extension of an existing professional identity or represents a new primary professional identity. Despite the rich history of mental health consultation, the consultant role has been considered marginal in each of the four basic mental health disciplines—to a greater or lesser extent, depending upon the specific discipline. Yet, it has represented a new, refreshing, and frequently more fulfilling mode of practice for many professionals who felt constrained in their more traditional disciplinary roles. Thus, consultation—especially community-based consultation—has served as an important "safety valve" for the disciplines. This is true both for those whose primary professional identity is as a consultant and for those who continue working in traditional professional roles but who consult as a secondary activity. At the same time, consultation has the capacity for expanding the roles, practices, and knowledge bases of the disciplines themselves. Thus, it can be viewed not only as a release from disciplinary restraints and sanctions but also as an opportunity for increasing the scope and expertise of professional intervention and knowledge bases within and between the disciplines themselves. As this opportunity is encouraged—as more professionals come to view their primary role as that of "consultant"—the issue arises

as to whether or not the role is sufficiently different from the profession of origin to be considered distinctive. The increasing knowledge base, the assertion that ethical issues in consultation are not easily clarified by the ethical standards of other professional roles, and the clear evidence that consultation activities are proliferating across populations and settings argues that the preconditions for consultation as a primary professional identity are discernible.

- Specific emphases in mental health consultation reflect diversification.

Mental health consultation, as portrayed by the contributing authors and in the updated annotated bibliography, is expanding to new settings and populations. While the majority of activity still takes place in schools and health settings, there is a spread of consultation into a broader range of traditional settings, as well as consultative interventions into nontraditional or emerging settings. In part, this proliferation of settings which are amenable to consultative intervention is due to the increasing receptivity to social psychological principles by the various institutions and organizations concerned with quality-of-life issues. The willingness of mental health professionals to enter uncharted territory and provide consultation services on unfamiliar terrain also contributes to the apparent proliferation of settings in which mental health consultation is being conducted.

In terms of populations, new groups--particularly self-help groups--are receiving increased attention for consultation services. Newly visible special populations such as alcoholics, the deaf, and the retarded (across all age groupings), and sexually abused children and adolescents also are the beneficiaries of consultative services. In addition, adult rape victims, widows, and geriatric populations are increasingly mentioned in the literature as the ultimate clients of consultation efforts. Thus, the field is clearly expanding in terms of the range of clients or target populations.

Expansion of consultation to a wider range of consultee types also is evident. In particular, parents are increasingly cited in the consultation literature as consultees working with mental health professionals, frequently in the context of parent training, to improve the mental health of their children. Thus, while mental health consultation, in general, remains focused on those settings and populations which have characterized its

history, It is rapidly expanding its scope and diversifying its practice experience.

Similarly, mental health consultation is distinguished by its unique ability to encompass the three levels of preventive intervention within its confines. Although efforts at promoting primary prevention models have increased in recent years, there has been no diminution in the level of consultative activity on the secondary and tertiary levels. Rather, as interest in the primary preventive impact of mental health consultation has heightened, consultative activities which embody secondary and tertiary preventive principles have intensified. The resultant mix has contributed to the diversity and the dynamic energy of the field.

Debates Around the Current Status and Future Possibilities

This Handbook has attempted to portray many of the key strands of development in the field of mental health consultation as it now exists. Some of the overarching themes in the field, as suggested by the contributing authors, have been discussed in the preceding section. Yet, despite the richness of the field to date, it should be remembered that mental health consultation is still evolving--with many issues yet unresolved. Any effort to predict future trends must be rooted in the field's history and will flow from the resolution of current tensions. One can expect, as noted by Vernberg and Reppucci, that already achieved gains will be consolidated and integrated into the mainstream of the field. For example, we can reasonably expect a continuation of activities and forces noted in the preceding sections, which is to say a continued: (1) focus on the social context and support for system-level interventions, despite the array of powerful counterforces; (2) close interrelationship--at least paradigmatically--between consultation and notions of community-based prevention; (3) availability of consultation as an alternative role for mental health professionals; and (4) proliferation of and diversification in settings and populations touched by mental health consultation.

Much of the excitement of the field stems from its many unresolved issues and is marked by the vigor of the many ongoing debates which would seek to define, characterize, and regulate the field. Among those debates which will frame the context for the immediate and long-range future of mental health consultation are the following:

- Obstacles to interdisciplinary collaboration

Working in an emerging field, mental health consultants are simultaneously attempting to develop new roles requiring new competencies and ethical standards while remaining embedded in the practices and standards of their professions of origin. On the one hand, innovation needs freedom to flourish; on the other, professions need both social sanction and regulation to protect the public and publicize the values of their services. The tension between the push to professionalize and the urge to innovate is strong and, in the current climate, poses fundamental challenges to some of the key assumptions underlying the practice of mental health consultation. For example, many authors in the field of mental health consultation call for an interdisciplinary emphasis. Such an emphasis requires a reaching out to explore both commonalities and differences across disciplinary lines. However, this thrust is counteracted by the discipline-related pressure to regulate, presumably to screen out unqualified practitioners. This is usually preceded by efforts to develop standards for practice and training within the context of (and enforced by) the professional discipline. In so doing, efforts will be undertaken to define mental health consultation in terms of what is unique about mental health consultation for the specific discipline involved. The result is likely to be more segregation within the disciplines, at the expense of true interdisciplinary efforts.

Another constraint working against interdisciplinary efforts is found in current efforts to validate the consultation role within the professional disciplines, allowing those in the field to feel less marginal and to have more credibility and visibility within the mainstream of the discipline. This, as Kelly discusses, is supported by improved training; however, that training which is most likely to provide needed role validation will take place within the academic disciplines themselves. Therefore, the very forces which can enhance the role of mental health consultation could also, unwittingly, narrow the scope of the consultant's vision.

- Obstacles to collaboration between practitioners and researchers

In any evolving field of action, there is a clear and pressing need for collaboration between those who practice and those who study. Regrettably, there is a current lack of collaboration between practitioners and researchers in the field of mental health consultation such that the practice and the science of the field frequently

do not inform each other. Practitioners typically learn their consultation skills on the job and are likely to adopt a pragmatic eclecticism in their work, drawing on varied concepts from different models. Further, they often cannot find the time or do not have access to formal mechanisms to disseminate their experiences through conferences or formal publications. What formal training they do get--as Gallessich, Long, and Jennings indicate--is typically through programs sponsored by various professional and educational organizations, rather than in academic settings. Conversely, academically based researchers are more likely to be model-driven rather than pragmatically-driven, are more apt to be peripheral to the real-life interplay within natural settings, and tend to focus either on large-scale models or on specific and limited techniques.

The socialization of practitioners suggests that many lack an empirical foundation which could enlighten their work, while the socialization of researchers suggests that their conceptual models may not be sufficiently informed by the firsthand experience of practitioners. While collections of case studies (e.g., Alpert and Associates 1982) would be useful for researchers, the field still faces a challenge in creating mechanisms which foster collaboration across the scientist/practitioner split. While this lack of collaboration is neither new nor unpredictable, such circumstances are particularly important to counteract in a field whose intellectual development needs to be stimulated by the collaborative interplay between practice and conceptualization.

- Limitations posed by shrinking economic resources

The fiscal retrenchment of the economy is directly shaping the practice, scope, and nature of mental health consultation. As the field attempts to defend and promote itself as a viable professional activity in an environment highly competitive for shrinking economic resources, it is easy to lose sight of the *raison d'etre* of mental health consultation. When the chase is on for funds, consultants may be pressured to generate income to ensure the survival of their sponsoring organizations--and the survival of their own jobs. There is a clear and present danger that the field could be preempted, by both the necessity and the willingness to provide whatever services generate funds, irrespective of the need for those services by the ultimate service recipients. For example, many consultation and education units of mental health agencies now are being utilized almost exclusively to conduct

the agencies' public relations and marketing activities. Such activities are justified as having redemptive value, and its practitioners attempt to incorporate these activities within their (flexible) definitions of consultation. While understandable on a pragmatic level, such activities are outside the scope of mental health consultation, as defined and illustrated in this Handbook. The challenge for the field is to adapt to the economic realities without compromising the basic integrity of the mental health consultation enterprise.

The scope and nature of consultation also are being impacted by economic incentives within the health care system; third-party payers increasingly are focusing on repayment for primary care services rather than on preventive interventions. With respect to mental health services, this payment philosophy disproportionately rewards those who provide individual treatment over those whose interventions are designed to radiate to the larger social context. Of lesser but still significant concern is the pullback from the commitment of resources to primary prevention efforts within the mental health consultation field itself. As Swift and Cooper note, consultation goals have been shifting over the last decade from case consultation to primary prevention interventions. However, since the bulk of resources is still targeted at case consultation, recent progress in the field--toward system-level interventions and a focus on the social context--is seriously threatened.

The keys to survival are flexibility, centering on the basic goals of mental health promotion, and a shared commitment to "keeping the faith" during very difficult times. Further, it is important not to blame all problems regarding the development of the mental health consultation field on economic considerations--despite the ample justification for doing so. Rather, as funds become more limited, there is potential for mental health consultants to remain true to their calling while, at the same time, surviving by promoting consultation as an economical and efficient way of introducing expertise into organizations and communities. That is, consultation allows an infusion of a high level of expertise from a professional who might otherwise be unavailable or uneconomical for full-time staff membership. Organizations also are facing economic retrenchment and are being challenged to respond without a sufficient level of understanding or expertise to carry out their mandates. Mental health consultants' skills in assisting consultees to adapt to changing social

environments in ways which promote mental health are particularly relevant in these changing times. Consequently, mental health consultants will have a unique vantage point and will obtain important experience, translatable into the further development of conceptual models, generation of research, and improvement of practice.

- Other ongoing debates in the field of mental health consultation

In addition to the concerns noted above, the field of mental health consultation continues to struggle with long-standing controversies which have shaped the field but which are as yet unresolved. Among those noted by the contributors to this Handbook are: (1) sharp differences in definitions of mental health consultation and considerable expenditure of energies and talents in a probably unachievable effort to develop a universally accepted definition; (2) likewise, efforts to promote a single conceptual model of mental health consultation despite the realization that consultation practice is apt to be supremely eclectic, borrowing what seems to work from many different models which appear to be theoretically contradictory; (3) the current emphasis on the development of primary prevention models despite evidence that the preponderance of activity in mental health consultation still is directed at secondary and tertiary levels of preventive impact; (4) the debate over the nature of mental health consultation as an indirect or as a direct service, colored by political considerations of funding implications and the urge for professional respect; and (5) the concern for ethical implications implicit in the consultant role and the development of adequate safeguards to protect consumers.

Gaps in the Mental Health Consultation Literature

In an attempt to provide a reference guide to the field of mental health consultation, the authors of this Handbook have necessarily restricted its source domain to the published literature. Yet, we are keenly aware that much of the rich experience of the field is not documented in the literature, so that it is lost to the body of knowledge which currently is being constructed and disseminated. The large, undocumented experience of the mental health consultation field constitutes the most significant gap in the literature.

The very determination of what constitutes a gap in knowledge is dependent upon one's personal paradigm of consultation. Indeed, as we have seen, mental health consultation is represented as many different aspects with many contending viewpoints. However, we will use the definition of mental health consultation set out in the Introduction to this Handbook which has guided the discussions of the contributing authors. We suggest the following as deficits in the literature which merit close attention and action:

- Ecological considerations of mental health consultation are still in need of development.

Although contextual considerations have been cited over a period of years as important influences on mental health consultation, the associated literature remains predominantly acultural and ahistorical in its emphasis. Ecological issues such as geographical diversity, for one, are in need of further elaboration. For example, in recent years we have seen an increase in reports of consultation in rural settings which acknowledge the value of understanding how geographical arrangements relate to the definition of problems and to the delivery of consultation services. Yet, it simultaneously underscores the implicit urban bias embedded in much of the mental health consultation literature.

The authors contributing to this Handbook differ in the extent to which they emphasize ecological and systemic factors in the host setting and in the broader culture as influencing mental health consultation. For obvious reasons, the process consultation and organizational development perspectives best represent the importance of the immediate context as being of central conceptual interest. This Handbook has introduced some of the salient contextual aspects of consultation for which some literature is available including issues of training, differing orientations to defining and practicing mental health consultation among the professions, and ethical concerns. However, a host of other contextual factors continue to be poorly represented in the consultation literature. In sum, while consultation has strong roots in periods of social reform and efforts at systemic change, it has yet to fully dedicate itself to explore how ecological/contextual factors affect the consultation process.

- The positive value of cultural diversity needs to be stressed in view of its underrepresentation in the field.

Echoing the preceding discussion of the underdevelopment of broader ecological perspectives, we have found that cultural diversity also has been seriously

underrepresented in both theoretical development and research on mental health consultation. Such issues as race, gender, and age also provide a critical context for understanding the consultation process. There is, for instance, a relative paucity of publications—documenting both experimental research and descriptive case studies—which focus on the race or ethnicity of consultant, consultee, or client as variables affecting either the process or content of the consultation. Indeed, a recent review by Gordon and Steele (1984) reveals fewer than 35 published articles on this topic in the past 20 years.

Similarly, issues of gender are generally neglected in the literature, belying an attitude that gender is not a particularly salient variable for understanding the process or content of consultation. The well-established Women's Movement notwithstanding, very few published articles discuss women's issues as they relate to mental health consultation. More typically, the few gender-specific articles focus on women consultants operating within roles or settings considered nontraditional for women (Frederick et al. 1976; Bayes and Newton 1978).

These gaps in cultural identification mirror society at large insofar as the less powerful remain virtually invisible. Since that which is documented and public carries with it an implicit power, the lack of activity to publish in these areas further limits from visibility the concerns of the culturally ascribed powerless. Several reasons for this underrepresentation have been suggested, including observations that there are few material incentives for working with the less powerful and limited interest on the part of publishers in publishing the results of these usually small-scale efforts. Recognizing this area as a critical gap in the literature, where there are choices to be made, consultants can seek out opportunities to work among those groups now underrepresented in the field and assure that the experience and outcomes of the effort will be both documented and public.

- Research on mental health consultation is promising but fragmented, scattered, and relatively isolated in varied fields of practice.

One final gap we view as critical to the long-range viability of the field is the gap between the current research base on which consultation rests and the research needs of the field. The chapters in this volume highlight several different aspects of research which need attention. First, there is the need for research which is

programmatic and involves the so-called "big questions" in the field. These questions deal not only with the various techniques and strategies represented in different models of consultation; they also involve some of the fundamental assumptions on which much of consultation rests. Kenney's review of consultation research, for example, suggests that consultation can be an effective form of intervention with the consultee although it less clearly "radiates" to the client. This assumption of radiating effects is fundamental to the notion of consultation as a form of indirect service. Thus, research on this specific topic is critical to the field. Kenney points out that, in terms of necessary resources and issues of design and measurement, programmatic research in mental health consultation continues to be difficult, particularly on those aforementioned "big questions." Such programmatic research as does exist is focused mostly on specific aspects of consultation process and technique.

A second general issue in research on consultation involves its variable quality. Indeed, many assert that research in this field is, overall, relatively weak. Several possibilities are evident which constrain the field from generating the quality and quantity of well-designed empirical research that is needed. First is the inherent difficulty of conducting longitudinal research in field settings which, to be comprehensive, requires external support. Examples of such long-term community research commitments are rare, suggesting the potential value of collaborations among investigators working in different sites on mutually agreed-upon questions. A second constraint is the previously mentioned gap between practitioners and researchers. Those involved in the practice of consultation, especially those involved in long-term consultative efforts--are typically neither trained to conduct research, nor are they provided the resources necessary to do so. Especially in times of scarce resources, research assumes a lower priority for practicing consultants than it might under more affluent conditions. This constraint highlights yet another reason for the development of meaningful collaborative relationships.

Kenney notes that some problems in carrying out sustained and additive research in mental health consultation are generic to all applied research. However, other problems are unique to mental health consultation and thus need to be addressed by the field directly. He suggests, for example, that the field begin to build a body of knowledge through the accretion of comparative findings,

meanwhile discouraging the proliferation of discrete, unconnected findings. He also reminds us that technologies now exist which make possible innovative solutions to some of the problems which have frustrated this field in the past.

The development of new methodologies, statistical techniques, and substantive contributions to intervention theory in various disciplines reinforces the importance for the research community of spanning disciplinary boundaries. The current state of research in the field, however, is frequently discipline-defined and discipline-bound. While, as Kelly points out, the relationship of various disciplines to consultation is constrained by the unique histories of the professions themselves, similar constraints are found in the consultation literature within the separate disciplines. Most frequently, research on consultation derives from and refers to prior literature in the "home" discipline, rather than building on the shared knowledge base across disciplines. While the disciplines do bring distinctive perspectives to bear on consultation, they also share significant issues and have developed concepts or techniques which can inform the development of consultation *per se*.

While other fields also are noted by fragmentation and isolation of research, there are signs of progress on both methodological and theoretical fronts. Kenney points out how research design advances in other fields can stimulate increasingly sophisticated and persuasive research in consultation. Also, a creative tension is emerging in the literature involving the interplay between research which is model-inspired and the more descriptive case studies. Model-driven research enables assessment of the adequacy of various models and confronts their current limitations. Vernberg and Reppucci, for example, clarify how the precision and observational specificity of learning theory have enhanced an appreciation of the complexity of the social context and its impact on problem behavior. On the other hand, an increasing number of case studies have provided an enlarged data base from which to develop heuristics about the important aspects of consultation and the multitude of factors which may affect both its process and outcome. Such case studies typically are not model-inspired, yet many provide necessary descriptive materials for more enlightened model building.

In sum, research in mental health consultation, while promising, is in need of increased efforts not only in the technical areas of research methods and measures, but also in the development of the substantive content of mental health consultation. This could more readily and more adequately be obtained through productive collaborations across mental health disciplines, between scientists and practitioners, and among mental health consultation practitioners. Though the current research literature is scattered and fragmented, the potential for significant progress is increasingly recognized.

Conclusion

The development of this Handbook has allowed a relatively broad picture of mental health consultation, in its various forms and concepts, to emerge. At the same time, we have attempted to sharpen critical issues, illuminate differing underlying paradigms, and highlight potentially important factors which are relatively obscured or underrepresented in the field at present. The Handbook will accomplish its intent to the extent that it stimulates further discussion and development of the field of mental health consultation.

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PART VI

**AN ANNOTATED REFERENCE GUIDE TO THE
CONSULTATION LITERATURE, 1978-1984**

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Introduction

This bibliography is the third addendum to Mannino's reference guide to the mental health consultation literature published in 1969. The second addendum was edited by Grady, Gibson, and Trickett and published in 1981; it included 884 annotated references to journal articles, dissertations, and books published from 1973 through July 1978. This third addendum includes 683 annotated references to journal articles and additional references to dissertations and books published from 1978 to 1984. References for the second addendum have been selected from Dialog File II: PsychInfo (obtained from an NIHM search), Index Medicus, Dissertation Abstracts, and the National Institute of Mental Health Clearinghouse. Although a great deal of effort has been made to ensure the comprehensiveness of the addendum, the coverage may not be entirely exhaustive. The annotations of journal articles represent reprinted, shortened, or paraphrased versions of the abstracts included in the sources named above. Reprinted abstracts written by authors or editors are credited by (abs.).

As in the second addendum, publications were included if they reflected a concept of consultation as a triadic interaction among consultant, consultee, and client involving indirect service and concerning some aspect of mental health. Journal articles, dissertations, and books which specified a two-party network, an intervention which was not service oriented, a direct service orientation, or intervention goals which were not related to mental health were excluded. Additional publications were included if they discussed an interaction between consultant and client system in general, consultative interventions at a general level without specifying goals, or mental health as a secondary goal of intervention.

The classification scheme appearing in the second addendum has been maintained as follows:

1. Mental Health Consultation Models and Approaches
2. Mental Health Consultants by Fields of Practice
3. Consultees by Consultative Settings
4. The Process of Mental Health Consultation
5. Research on Mental Health Consultation

The previous reference guides and this addendum continue to be the only comprehensive bibliographies on mental health consultation which attempt to classify entries according to categories. Because of the large number of entries included, many of the publications were selected and classified solely on the basis of title or abstract. For this reason, certain publications may have been inappropriately selected and/or classified, while others may have been cross-referenced inadequately.

Consecutive numbering of all entries has been maintained to facilitate cross-referencing and to avoid repetition of entries. As in the previous reference guides, the numbers following authors' names in the Author Index correspond to the numbered entries in the text. This procedure facilitates the location of any particular entry.

1. JOURNAL ARTICLES

Mental Health Consultation Models and Approaches

Behavioral Consultation Model

1. Ajchenbaum, M., and Reynolds, C.R. A brief case study using behavioral consultation for behavior reduction. *School Psychology Review* 10(3):407-408, 1981.

Maintains that the consultation model used in schools is beneficial because it (a) allows the psychologist to handle more cases since the intervention is cooperatively implemented, (b) promotes greater utilization of the teacher on an equal professional level with the psychologist, and (c) enables the teacher to generalize new intervention skills to similar situations in the future. The effectiveness of the model is demonstrated with the case of a 7-year-old male whose finger-in-the-mouth behavior was eliminated with a consultant-teacher-parent reward system.

2. Berger, M. Behaviour modification in education and professional practice: The dangers of a mindless technology. *Bulletin of the British Psychological Society* 32:418-419, 1979.

The potential dangers of fostering a simplistic approach to behavior modification by psychologists are discussed. Such dangers arise in training and practice and stem from the conjunction of two features of behavior modification and professional approach consisting of consultation without observation and ongoing support. The two features are the apparent simplicity of the technique (common sense) and enthusiasm for teaching the techniques to nonpsychologists, particularly teachers. The misuse of behavioral principles and techniques in this manner seriously detracts from their contribution to education.

3. Gresham, F.M., and Nagle, R.J. Treating school phobia using behavioral consultation: A case study. *School Psychology Review* 10(1):104-107, 1981.

Presents a case study to illustrate how behavioral consultation can be used by the school psychologist with a modification and expansion of W.A. Kennedy's (1965) "rapid treatment method" in eliminating school phobia. The importance of including teachers as well as parents and administrators as consultees and participants in the decision-making process is demonstrated.

4. Kratochwill, T.R., and Bergan, J.R. Evaluating programs in applied settings through behavioral consultation. *Journal of School Psychology* 16(4):375-386, 1978.

A behavioral consultation school psychology service model is presented which provides a vehicle for services and communication of process and outcomes measures in program evaluation research. Within the context of the problem-solving perspective of applied behavior analysis, the consultation model promotes process and outcome evaluation across a wide variety of settings, situations, and time; leads to use of an applied research technology with wide applicability in educational settings; and provides a communication technology for the program evaluation process through a four stage problem-solving strategy. It is argued that the professional behavioral school psychologist can provide technical expertise to function as a system change agent within this evaluation model.

5. Reichelt, S. Experiences from a behavioural counseling model. *Nordisk Tidskrift fore Beteendeterapi* 7(2):87-104, 1978.

The practical applications of a consultation model based on behavior therapy, originally developed by Tharp and Wetzel (1969), are discussed. The most commonly used methodological designs ($n=1$) are considered as they relate to recent research and to application of the model in an outpatient clinic for children and adolescents. Finally, the efforts of a group of behavior therapists to add communication theory to social learning theory are described. (abs.)

6. Williamson, G.A., and Barrios, F.X. Liaison psychiatry in daily medical practice. *Annual Review. Behavioral Group Therapy* 1:269-287, 1980.

A behavioral consultation experience in a fledgling day hospital program is described. The consultation demonstrated that highly successful behavioral techniques such as token reinforcement and response cost can fail in a particular setting through design error, staff resistance, patient countercontrol, and/or weak system support. It was learned that successful behavioral consultants must know the consultee's system, their own role in that system, and patient attitudes toward the proposed treatment approach before implementing an intervention program. (abs.)

See also:

49, 146, 251, 262, 331, 346, 392, 412, 463, 474, 476, 528, 553, 554, 570, 571, 579, 583, 584, 630, 673, 679, 696, 697, 712, 727, 739, 751, 752, 756, 778, 795, 798, 824, 848, 853.

Organization Development Consultation Model

7. Dirks, M.J.; Rottinghaus, M.K.; and Lansky, L.M. Argyris' intervention theory: A small-group application. *Group and Organization Studies* 3(3):317-330, 1978.

A case study of a consultation is presented that illustrates how two theories concerning organizational change and systems analysis were applied to a small, informal organization. The primary intervention tasks outlined by Argyris (1970) were applied throughout the consultation and the systems theory detailed by Katz and Kahn (1966) provided a conceptual model for organizing and discussing the data. Systematic intervention with small, less structured groups is advocated.

8. Frohman, M. A. The need for a model--and a viewpoint. *Group and Organization Studies* 8(1):15-18, 1983.

Comments on a paper by P.M. Nufrio concerning Nufrio's development and learning as an internal consultant. An organizational development approach to consulting offered by D.A. Kolb and the present author can be used to clarify Nufrio's experience and to enhance the learning.

9. Ganesh, S.R. Organizational consultants: A comparison of styles. *Human Relations* 31(1):1-28, 1978.

Insights into organizational consulting styles are provided through a summary of results of research on 21 leading organizational consultants, 11 in the United States and 10 in India. Three approach-related and three person-related elements of styles are elaborated upon, using data from indepth client-centered interviews with the consultants. Two distinct styles of organizational consulting emerge from the data and their relation to values, approaches, and consulting experience are discussed, as are their interrelations. An underdeveloped aspect of organizational development literature is the need for understanding individual organizational consultants and their styles, which influence their interventions. It is concluded that through understanding styles one can begin to appreciate and understand the application of behavioral science knowledge to the development of organizations.

10. Lennox, N.; Flanagan, D.; and Meyers, J. Organizational consultation to facilitate communication within a school staff. *Psychology in the Schools* 16(4):520-526, 1979.

An organizational consultation intervention designed to create a more effective learning atmosphere by improving intrastaff communication in an urban school is described. Using an informal

survey accompanied by feedback sessions, a tense school atmosphere was relaxed and a process for ongoing, cooperative problem-solving was developed. A concrete description with emphasis on practical considerations is offered to stimulate programs of intervention at the organizational level, which, although efficient, are rarely used consultation techniques.

11. Nicoll, D. Organizational termination as an organization development issue. *Group and Organization Studies* 7(2):165-178, 1982.

Discusses consulting experience with a dying organization and the intervention strategies with which the author experimented. Also described are the behavioral reactions of the staff to their organization's termination: Paralysis, catastrophic fantasizing, exaggeration of organizational hierarchy and power, language shifts, and personal disaffiliation with the agency. It is suggested that a staff's acceptance of their organization's demise may be aided by work on a focal issue such as personnel transfers.

12. O'Donnell, R.J., and Geer, L. N. A systems approach to OD. *Training and Development Journal* 36(4):96-98, 1982.

Examines the systems approach to organization development (OD) that entails an ongoing committed relationship between consultant and client. OD practitioners are increasingly involved in interviewing managerial candidates, counseling individuals with problems and career choices, and evaluating current employees' performances. A model for an OD consultant's initial involvement with a client firm is outlined. Support data from finance, consumer products, and banking firms are presented to demonstrate how difficulties in this assessment process are overcome.

13. O'Toole, D.E., and Marshall, J. Experimenting with OD. *Training and Development Journal* 36(4):58-65, 1982.

Observed interactions between an external organization development (OD) consultant and six groups of public officials to determine behavioral facets of the OD process, the roles of an external OD consultant, and how public officials would use such a resource. The ability of the OD process to surface concerns, consultant self-awareness, training and management, and the discounting of a free resource are discussed. The utility of such OD experiments as a major source of knowledge is noted.

See also:

61, 76, 148, 333, 429, 430, 435, 464, 467, 525, 531, 536, 573, 600, 602, 604, 619, 620, 627, 636, 684, 693, 699, 721, 742, 743, 745, 749, 761, 795, 819.

Systems Consultation Approaches

14. Benitez, R. Psychiatric consultation with clerical staff: A systems approach. *Social Casework* 60(2):75-80, 1979.

A psychiatric consultation for clerical staff in a mental health service delivery agency, undertaken to assure that all client contact with staff had a beneficial effect on treatment, is described. A systems approach to staff/client interaction points to the need to integrate all aspects of agency service delivery. In this agency, special training for clerical staff proved beneficial to the total agency system. It provided the clerical staff with a sense of value and was helpful to the clients.

15. Douglas, J. A "systems" perspective to behavioural consultation in schools: A personal view. *Bulletin of the British Psychological Society* 35:195-197, 1982.

Presents an analysis of the social systems of primary schools and formulates a systems approach to behavioral consultation. The format of the approach includes the following: (1) problem situation definition, (2) analysis, (3) relevant systems, (4) conceptualization, (5) definition of change, (6) selection of change, (7) design of change, (8) implementation, and (9) appraisal. This format encourages the psychologist to look beyond the presenting problem to other more complex interactions within the school that interfere with the management of the referred case.

16. Fine, M. J., and Holt, P. Intervening with school problems: A family systems perspective. *Psychology in the Schools* 20(1):59-66, 1983.

Viewing children's behavior from a systems perspective allows the school-based consultant an expanded perception of the contextual function of the behavior. The two key systems in a child's life, home and school, often overlap so that what occurs in one system can affect the child's behavior in the other. By considering the relationships of the child to both home and school, a more holistic view of the child is obtained, and greater opportunity for family involvement is provided. The differences between systemic and linear approaches to behavior are discussed, and examples are provided of how the school-based consultant can intervene from a systems perspective, using interviews, short-term family counseling, and teacher consultation. Cautions about using a systemic approach are outlined.

17. Glazer, W. M., and Astrachan, B.M. A social system approach to consultation-liaison psychiatry. *International Journal of Psychiatry in Medicine* 9(1):33-47, 1979.

Several organizational themes for the consultation/ liaison psychiatrist, based on the social systems theories of A.K. Rice and W.B. Miller, are discussed. The relevance of these themes are applied to case material taken from a year's experience of consultation/liaison in a hemodialysis unit of a general hospital. It is concluded that a social systems approach facilitates attention to important issues of primary task, boundaries, and division of labor, authority, and management, which affect patient care and influence patient behaviors.

18. Mohl, P.C. Group process interpretations in liaison psychiatry nurse groups. *General Hospital Psychiatry* 2:104-111, 1980.

Nurse groups are generally viewed as supportive adjuncts to other forms of liaison psychiatry interventions. Recent developments in systems approaches to liaison psychiatry suggest that such groups may be used to alter the values, norms, and behavior of a unit system since nurses are viewed as the culture bearers and socializers of units. This article reports the results from five units in which this approach was attempted.

19. Mohl, P.C. A review of systems approaches to consultation/ liaison psychiatry. The need for synthesis. *General Hospital Psychiatry* 3(2):103-110, 1981.

Five applications of systems theories to liaison psychiatry are reviewed. "Systems" is noted to have three distinct meanings as applied to consultation/ liaison psychiatry: as a metatheoretical construct, as a decisionmaking process, and as an organizing construct for social variables. It is proposed that the time is ripe for synthesis of the social systems theories, reduction to the most parsimonious use of variables, and empirical testing of their importance.

20. Tarnow, J.D., and Gutstein, S.E. Systemic consultation in a general hospital. *International Journal of Psychiatry in Medicine* 12(3):161-186, 1982.

Over the last 50 years, since the initiation of consultation psychiatry, a series of models of consult work has been presented in the literature. After reviewing the history of consultation psychiatry, the authors conclude that a logical development would be a systemic model in which the entire hospital system is seen as the focus of consultation and in which the goal of the consultant's

work is seen as creating a more open and flexible hospital system. The authors, therefore, describe a systemic model in which the potential crisis offered by any request for consultation work is seen as a tool for intervening with the hospital system. A method of systemic diagnosis of the hospital is presented as well as a number of strategies of intervention with the hospital system.

See also:

12, 147, 429, 819.

Traditional Mental Health Consultation Model

21. Hyland, J., and Book, M. A psychoanalytic orientation to consultation-liaison psychiatry. *Bulletin of Menninger Clinic* 45(5):395-408, 1981.

This article reviews psychoanalytic theories about medical illness and presents clinical examples that illustrate applications of a psychoanalytic orientation to medical illness, toward the development of a psychoanalytic framework for consultation/liaison psychiatry.

22. Janssen, P.L. On some psychotherapeutic aspects of occupational therapy in a psychiatric hospital. *Psychotherapie—Medizinische Psychologie (Stuttgart)* 28(6):183-193, 1978.

Experiences of a psychoanalytically oriented occupational therapy consultation in a psychiatric hospital are described. The dynamics of both group and individual relations in the consultation are discussed, and resistances to therapeutic encounter, building ego strength, and the uses of introspection are described. Problems in maintaining a therapeutic presence in the consultation are addressed.

23. Kettler, A.R. Report on the annual conference of the German Psychoanalytical Society (founded in 1910). *Zeitschrift für Psychosomatische Medizin und Psychoanalyse* 25(2):183-188, 1979.

A summary of the annual conference of the German Psychoanalytical Society, held at the Hardtwald-Klinik II in Zwesten, West Germany, in October 1978 is presented. Reasons are given why a clinic was selected for a psychoanalytical congress, and subjects discussed by individual speakers are mentioned briefly. The theme of the conference was the further development of methods of psychoanalytical treatment. It was divided into three reports handled by a total of 10 work teams which dealt with consultation techniques, short-term therapy, techniques of handling cases

involving a borderline syndrome, clinical and outpatient group therapy, the method of consultation in pairs, and motivation for psychotherapy, always emphasizing the psychoanalytical viewpoint. The concepts of monosymptomatic, black box, conditioning, and desensitization are no longer essential parts of psychoanalytical treatment. Psychoanalysts are now also concerned with feelings. Gestalt therapy is the first nonanalytical treatment which has found its way into psychoanalysis.

24. Manos, N. Resistances encountered in the consultation-training of the community mental health worker. *International Journal of Social Psychiatry* 27(1):33-36, 1981.

Describes the personal experience of a psychiatric resident as a consultant to a public welfare department in transition toward more responsible community mental health work. The psychoanalytic frame of reference is used, and difficulties in the consultation process are dealt with as resistances.

25. Mohl, P.C., and Burstein, A.G. The application of Kohutian self psychology to consultation/liaison psychiatry. *General Hospital Psychiatry* 4(2):113-139, 1982.

Explanations of emotional and behavioral response to illness seen by consultation/liaison psychiatrists include crisis theory, stress theory, classical Freudian theory, grief, and alexithymia. Recent developments in self-psychology are also useful. Kohut identifies empathy as central to the establishment and maintenance of a sense of personal integrity, self-esteem, tolerance, and administration of others; deficits may cause feelings of shame, humiliation, rage, emptiness, and hypochondriasis. Persons who experience insufficient empathy during development are particularly vulnerable to these findings at the slightest hint of decreased concern, support, or empathy from parent surrogates. They attempt to compensate with a grandiose self-image or by attachment to an idealized other. Prior formulations have considered illness a real or threatened object loss, with the lost object assuming symbolic significance in the individual's emotional or behavioral experience. However, illness may also be understood as a threat to the integrity of the self. This helps explain the range of emotional reactions observed and the disturbances in the doctor-patient relationship. Intervention is directed toward reconstitution of the self. Cases are presented to illustrate the application of this theory to formulation and treatment.

26. Perry, S., and Viederman, M. Adaptation of residents to consultation/liaison psychiatry. II: Working with the nonpsychiatric staff. *General Hospital Psychiatry* 3(2):149-156, 1981.

When working with the staff in general hospital, psychiatry residents may be overly competitive, solicitous, or detached. These defense reactions often arise because of the special challenges of performing a consultation, including the skepticism about the value of psychiatry and the demeaning or unrealistic expectations about what the psychiatrist can do. Furthermore, the psychiatry resident feels even more challenged if the attitudes and behavior of the staff must be changed for the patient's benefit. To affect this influence on the staff the psychiatry resident may need to assume a "liaison stance." This stance involves not only establishing a collegial alliance but also using modified therapeutic maneuvers to alter staff behavior. By applying psychodynamic knowledge to understand and potentially to influence the staff, psychiatry residents, as participant observers, can feel less helpless and frustrated by difficult liaison situations.

See also:

343, 454, 552, 566, 583, 592, 604, 696, 795.

Additional Consultation Approaches

27. Barbrack, C.R. Program consultation: A framework for development and improvement of special education and related services. *School Psychology Review* 9(3):239-246, 1980.

Outlines an approach to consultation that is intended to complement rather than replace the other more traditional consultation approaches found in the current literature. A distinction is made between the human and the program aspects of consultation. Problems and issues stemming from the adoption and use of program consultation are discussed. Guidelines and procedures for consulting with special education service delivery programs are illustrated.

28. Berger, N.S. Beyond testing: A decision-making system for providing school psychological consultation. *Professional Psychology* 10(3):273-277, 1979.

A decision-making model for provision of school psychological consultation services is presented which utilizes principles from reality therapy. A seven-step flow chart is presented which depicts three decisionmaking phases. These steps are (1) presentation of

specific problem, (2) completion of data collection, (3) establishment of team goal, (4) value judgment of goal-directed behaviors, (5) commitment to change, (6) development of team action plan, and (7) evaluation of the plan's efficacy.

29. Feldman, R.E. Collaborative consultation: A process for joint professional-consumer development of primary prevention programs. *Journal of Community Psychology* 7(2):118-128, 1979.

A mental health consultation process, collaborative consultation, by which professionals and nonprofessionals or paraprofessional community consumers of psychological services together can develop prevention services designed for eventual implementation by qualified consumers, is described. Collaborative consultation adheres to mental health consultation conventions, while combining features of consultation with those of collaboration. Results show that collaborative consultation provides an opportunity for consumers themselves to exercise power in decision-making concerning the fine details of service programs and in the day-to-day delivery of the service. It is suggested that future research should involve mixing collaborative consultation with other program development processes.

30. Freeman, C.K. Transactional analysis: A model for psychiatric consultation in the general hospital. *Nursing Forum* 18(1):43-51, 1979.

The use of transactional analysis as a model for psychiatric consultation with nursing staff in a general hospital is described. In determining the psychiatric approach to help nurses interact more effectively with difficult patients, consultants should understand that the problems most likely to result in requests for psychiatric consultation involve breakdown in communications which escalate emotional reactions and inhibit objectivity and therapeutic action. It is contended that transactional analysis is uniquely suited to this situation, since it is easily taught, provides a simple and practical framework for examining patient-staff and staff-staff relationships, provides a common language for staff and consultant, and is easily implemented.

31. Gibbs, J.T. The interpersonal orientation in mental health consultation: Toward a model of ethnic variations in consultation. *Journal of Community Psychology* 8(3):195-207, 1980.

A model of an interpersonal orientation to mental health consultation is proposed to conceptualize the initial response of black consultees to the use of consultation. The model describes five

stages in the consultee's approach to the entry phase of consultation, along with five corresponding dimensions of behavior evoked by the consultant. It is suggested that blacks, due to a combination of historical circumstances and cultural and social patterns and values, initially focus more on the interpersonal aspects of the consultation relationship than on the instrumental aspects. Seven critical incidents are described to illustrate the differences between black and white consultees in inner-city school settings. The implications of the proposed model are discussed in terms of its applicability to other interpersonal transactions such as the therapeutic relationship, student-administrator relationships, and other professional relationships. Finally, the usefulness of the concept of an interpersonal orientation which is distinct from an instrumental orientation is demonstrated.

32. Hughes, J.N. The application of cognitive dissonance theory to consultation. *Journal of School Psychology* 21(4):349- 357, 1983.

Cognitive dissonance theory maintains that when a person holds two conflicting cognitions, tension is created and the person is motivated to change at least one cognition to reduce the dissonance. In consultation, the consultant may want to suggest a course of action that is discrepant with certain consultee attitudes and beliefs so as to motivate the consultee to change relevant attitudes in the direction of consistency with behavior. The new attitudes will then support and maintain the new behavior. A research review suggests practical applications of cognitive dissonance theory to consultation. It is suggested that teacher-consultees will show a more positive response to consultation when the consultation is presented under conditions of high choice, when the consultee is given low justification for trying a new approach, and when consultees are required to expend more effort to obtain consultative services.

33. Knoff, H.M. The practice of multimodal consultation. An integrating approach for consultation service delivery. *Psychology in the Schools* 21(1):83-91, 1984.

Multimodal consultation provides a problem-solving approach that recognizes and analyzes the components of multifaceted, multi-subsystem referral problems. The approach, which is exemplified in the present article with the ecological perspective, consists of five parts from the identification and analysis of maladaptive interactions that cause, support, or maintain a referral problem's environment to the evaluation of consultation interventions that target different aspects of the referral environment and are based

on different consultation models. Multimodal consultation is primarily a conceptual model at this time; however, suggestions for empirical and heuristic research also are discussed.

34. Langman-Dorwart, N. A model for mental health consultation to the general hospital. *Journal of Psychiatric Nursing and Mental Health Services* 17(3):29-33, 1979.

The means by which a consulting mental health nurse may clarify the immediate needs of a nursing staff in a general hospital by teaching assertive behavior through role-playing situations are described. Assertiveness training is defined as the honest verbal expression of feelings without experiencing anxiety or guilt. Reinforcing assertive behavior is done by positive verbal support of assertive communications and group discussions of the application of the successful communication to other role-playing situations. A case example illustrates the role-playing process. It is concluded that assertiveness training supplements the traditional model of consultation to public health nurses and social service agencies.

35. Lawler, M.H. Termination is a work group: Four models of analysis and intervention. *Group* 4(2):3-27, 1980.

Four alternative models for understanding and consulting with work groups are presented. The models are a psychological model, information/communication model, a bounded rationality model of decisionmaking, and an incentives systems model. The major propositions of each model are summarized and then applied to the same case of work group functioning. The importance of increased attention to the functioning of professional work groups as a means of improving training and the delivery of health services is emphasized. It is concluded that such analysis should include the use of social science models as well as the more commonly employed understandings derived from the intrapsychic model of group behavior. (abs.)

36. O'Neill, P. Cognitive community psychology. *American Psychologist* 36(5):457-469, 1981.

Suggests that the study of cognitive processes can provide a conceptual base for community psychology. Community consultation is used as a vehicle to examine the utility of concepts drawn from cognitive psychology, cognitive social psychology, and studies of decisionmaking. These concepts are related to three areas of focus in consultation: the relationship between consultants and the host group of constituency, intragroup processes, and relationships among segments of the community.

37. Schmidt, J.J., and Medl, W.A. Six magic steps of consulting. *School Counselor* 30(3):212-216, 1983.

Discusses the need for continued development of practical consulting models, and outlines one view of consultation that has been presented by the authors in workshops for school counselors, psychologists, and other helping professionals. The model is designed for consulting relationships that focus on specific concerns and advocate a collaborative effort in finding solutions. Six steps that provide a schema by which a consulting relationship can unfold gradually, giving every decision and step a specific purpose and goal, are presented.

See also:

23, 75, 250, 341, 373, 407, 552, 592, 737, 778, 779, 780, 794, 830.

Mental Health Consultants by Fields of Practice

Community Mental Health Centers

38. Ahmed, M.B. Attitudes of mental health center staff: Changes over a five-year period. *Hospital and Community Psychiatry* 29(4):240-242, 1978.

A study of attitudes of mental health center staff toward priorities and problems in eight community mental health centers is compared with a study conducted 5 years later, using the same questionnaire, of attitudes of staff in one of the centers. Between 1968 and 1973 the number of psychiatrists decreased and the number of psychologists and social workers increased. The most significant change in priorities in 1973 was the higher ranking of consultation and education services. While staff saw their problems in 1968 as role diffusion and inadequate program planning, by 1973 they were concerned with administrative problems and with shortcomings in the quality of clinical care due to a lack of resources.

39. Bass, R.D., and Rosenstein, M. The indirect services: Consultation and education and public information and public education, federally funded community mental health centers, 1975. Statistical Note 147. Rockville, Md.: NIMH, March 1978.

Consultation and education (C&E) and public information and public education (PI&PE) services at federally funded community mental health centers (CMHC) in March 1975 are described in relation to (1) total CMHC programs; (2) differences in centers

with respect to organizational type, number of years in operation, affluence and urbanization status of the catchment area, and HEW region; and (3) changes in program operations over time. On the average, C&E and PI&PE activities occupied the time of roughly three and one full-time equivalent staff persons per center, respectively.

40. Bigelow, D.A., and Beiser, M. Rehabilitation for the chronically mentally ill: A community program. *Canada's Mental Health* (Ottawa) 26(2):9-11, 1978.

The Greater Vancouver Mental Health Service is an experimental program to provide direct treatment services to the seriously mentally ill in the community to minimize or remove the necessity for inpatient hospitalization care. Services provided to patients include assessment; individual, family, and group counseling; recreational and vocational activities; and medication. Patients are helped to solve their financial, residential, work, legal, and interpersonal problems. The service provides public education and case and program oriented consultation to other agencies that deal with the target population. The structure of the agency and the programs are described. Goals of the program are to treat the severely and chronically ill mental patient who would otherwise require long-term hospitalization; to reduce the incidence of hospitalization and, in cases where hospitalization becomes necessary, make earlier discharge possible; to reduce the cost of care for high-risk patients; and to develop growth-enhancing rehabilitative programs for seriously mentally ill patients.

41. Borislow, B. Community mental health: A backward look for the future. *Administration in Mental Health* 6(1):84-88, 1978.

In a letter to the editor, a position paper to clarify conflict between and among the staff of an inner-city community mental health center, its community advisors, and the institutional sponsor is presented. Prepared in 1969, the paper has implications for current issues in community mental health planning. These include primary preventive and consultation and educational services; deinstitutionalization and community care; new roles for mental hospitals; priorities, program planning, organizational development, management for objectives, accountability, evaluation, and cost effectiveness; and research and training in the service of mental health.

42. Brown, V.B. "Community Rape Prevention Program." Final report, NIMH grant R18-MH-29308. Unpublished paper, 1979. 81 pp.

A rape consultation and rape education project, which was a collaborative effort between the Didi Hirsch Community Mental Health Center and the Los Angeles Commission on Assaults Against Women, and which was concerned with the prevention of rape and with the aftermath of rape is discussed. Education programs were presented to 400 students and 1,500 other individuals. A survey of experienced rape counselors was conducted, a list of generic reactions experienced during the rape crisis was generated, and contributions were made to the literature on victim reactions and counseling strategies. A sound/slide presentation which focused on rape and ethnic minority people was developed. A survey of rape-related attitudes was conducted among the five major ethnic groups in Los Angeles. Replicable program protocols were developed for community education programs. Measures for collaboration study--use of journals and analysis of journal content, which represents a methodological advance--were developed. A conference which focused on sexual assault from a cultural perspective was held. The foundation for a rape services network among agencies serving ethnic minority communities was laid, and some of the major obstacles to interagency collaboration were defined. A directory of sexual-assault-related services in the Los Angeles area was compiled and distributed. Community meetings that focused on problem-solving for community residents were organized.

43. Chutis, L. Special roles of mental health professionals in self-help group development. *Prevention in Human Services* 2(3):65-73, 1983.

Provision of services to self-help/mutual aid groups is a natural outgrowth of the goals, objectives, and activities of consultation and education departments of community mental health centers. Providing assistance at several stages of group development without challenging the autonomy and voluntary nature of self-help groups is a basic requirement for professionals involved in group development. With recognition of the needs and nature of such groups, mutually satisfactory long-term relationships can be established between self-help groups and mental health professionals.

44. Gordon, J.S. The runaway center as community mental health center. *American Journal of Psychiatry* 135(8):932-935, 1978.

The runaway centers that evolved in the late 1960's in response to the needs of troubled young people are discussed, and it is noted

that the youth centers are fulfilling the goals of the federally funded community mental health centers. The runaway centers provide their young clients with the five basic services intended for the community mental health centers: inpatient services, outpatient services, emergency services, partial hospitalization, and consultation and education. Services are individualized and economical. These runaway centers can serve as a model for a variety of community services, such as drop-in centers for troubled individuals, mediation centers for families, shelters for battered women, and residences for people suffering an acute psychotic break.

45. Hadley, T.R.; Zuckerman, E.; and Cymerman, B. The impact of a satellite facility on the delivery of mental health services. *Hospital and Community Psychiatry* 29(6):360-361, 1978.

A study to determine the impact of a satellite facility on a mental health center's delivery of services to its catchment area was conducted over two 6-month periods. The opening of the satellite center greatly increased the number of referrals to the mental health team; however, it did not affect the nature of the referral population in drastic ways. No significant difference was found in the rate of consultation and education services over the two time periods. Staff did report that many clients stated a preference for being treated in the neighborhood, which may have resulted in fewer premature terminations or greater acceptance of treatment. The findings do support the hypothesis that decentralized and community-based services are more accessible and visible.

46. Hess, R. 'Helping thyself' to mental health: Interview. *Innovations* 7(1):18-21, 1980.

Robert Hess, a psychologist who is supervisor of the division of consultation and education for the Orange County Community Mental Health Center in New York, is interviewed about his division's experiences in self-help groups. Hess describes the different self-help groups he has helped to organize and how the groups have been developed. The role of a center in a self-help group, the weaning of a group from center support, and the training and identification of leaders for a self-help group are discussed. Both successful and unsuccessful groups are examined.

47. Kagey, J.R.; Hall, G.A.; Fardy, R.E.; and Pulice, R.T. Managing prevention, consultation and education services. *Journal of Preventive Psychiatry* 1(4):409-418, 1982.

Diminishing resources have threatened the continued existence of prevention, consultation, and education programs as part of

community mental health centers' services. In an effort to maintain effective prevention, consultation, and education (PC&E) programs, a system was developed to better manage such programs. The major components of the systems were developed over a 2-year period and include management information reports, fiscal analyses, and PC&E records. The system has helped to reduce cost, increase income, improve service delivery, and validate the existence of PC&E services.

48. Kaswan, J. Power and caring. *Journal of Community Psychology* 7(1):40-41, 1979.

Community control over mental health services is discussed in terms of an article by Nassi (1978) which argues that mental health professionals, through their control of services, are more responsive to their own than to community needs. Nassi suggests that more direct control of community mental health center policy and practices by residents would make professionals more accountable to those being served. The location of control in the bureaucracy is important, but the key problem with community mental health centers, as with other human services, is that they have taken over most of the functions of caring. In order to get helping services back into the hands of the community, assistance must be given to strengthen informal social care-giving arrangements. Ideally, the arrangements would use professionals as informational consulting resources, and not as helpers or problem solvers except as a last resort.

49. Kuehnel, J.M., and Kuehnel, T.G. Community mental health. *Psychiatric Clinics of North America* 1(2):307-322, 1978.

Innovative behavioral programs which have been developed and tested for their effectiveness in the core service areas of community mental health centers, such as partial hospitalization, outpatient care, consultation, and education, are described. With regard to day treatment, the uses of a credit incentive system, educational workshop, and Behavioral Progress Record introduced as the behavioral approach at the Oxnard Day Treatment Center in California are examined. In addition, a workshop for married couples experiencing difficulties in their relationships is presented to illustrate one application of behavior therapy in an outpatient service. Indirect community services provided through consultation and education and the effects of behavioral programs on staff are also discussed.

50. Lee, A.R. Creating a mental health consultation package for community agencies. *Hospital and Community Psychiatry* 28(10):745-748, 1977.

The author designed a consultation package for a community mental health center consultant to present to the relevant agencies and organizations in the community. The consultation package is designed to create a series of regularly scheduled voluntary group meetings that center on the discussion of a case or a particular topic. The package also includes a written agreement, an evaluation procedure, and a 6- to 8-month free trial period. The steps for establishing a new consultative relationship and developing a consultation network are also outlined. By using those steps and the package, the author and his colleagues have successfully established consultation services with schools; with the welfare, probation, and police departments; and with organizations of physicians, nurses, and clergy.

51. Maypole, D.E. Developing a management information system in a rural community mental health center. *Administration in Mental Health* 6(1):69-80, 1978.

The manner in which one rural Wisconsin community mental health center developed a management information system and responded to the pressures for accountability from funding bodies and collateral agencies in the community is described. The center provides outpatient evaluation and counseling to three disability groups, 24-hour psychiatric and alcoholic care, and consultative and educational services. By sharing its Federal grant funds, it secures day treatment and hospitalization services for psychiatric and alcoholic patients. The change model has three stages: readiness, action, and reinforcement. Implementation of the management information system using this model resulted in significant increases in work performance, while also permitting comparison of similar programs within the center.

52. Mental health service delivery in District of Columbia studied. *Mental Disability Law Reporter* 3(2):147-148, 1979.

A report by the GAO reviewing the delivery of mental health services by three District of Columbia mental health centers and by the DHEW-directed St. Elizabeths Hospital is explored. The GAO found that the lack of joint planning and coordination of services led to fragmentation of mental health services in the D.C. area: overlaps in such services as daycare, foster placement, and vocational rehabilitations; gaps in children's services, consultations, and education services; lack of equal access to services among

residents, especially children; and inadequate partial hospitalization services and followup procedures for discharged patients because of reorganization and program cutbacks. Recommendations for St. Elizabeths Hospital include more innovative approaches to treatment; reduction of patient readmissions; and improvement of admissions criteria, staff scheduling, and management of medical records and various therapy programs. Steps to alleviate the problems are identified.

53. Peck, B.B.; Howe, B.J.; and Stackhouse, T.W. Network psychotherapy as a community consultation technique. *Psychotherapy: Theory, Research and Practice* 15(1):95-100, 1978.

Uses family and network psychotherapy concepts to discuss a consultative approach to referrals to a community mental health center (CMHC). It is argued that frequently the referred person(s) represents only an isolated segment of a larger network. Further, this interpersonal system is considered to be an ongoing therapy endeavor that has reached an impasse. The purpose of the consultative stance is to provide an intervention allowing this larger and more involved system to transcend its impasse and proceed with the therapy already in progress. Two case examples are presented and discussed in terms of the process dynamics involved in the consultative technique and the demands placed on the CMHC staff.

54. Perlmutter, F.D., and Vayda, A.M. Barriers to prevention programs in community mental health centers. *Administration in Mental Health* 5(2):140-153, 1978.

The perceptions of administrative and professional staff about the feasibility of prevention programs in community mental health centers (CMHCs) were examined with emphasis on primary prevention. It is shown that prevention activities in CHMCs have been inadequately and inconsistently developed on what appears to be an unplanned, crisis-oriented basis. The data on perceived feasibility of prevention programs were obtained through interviews with 43 CMHC directors and 33 consultation and education directors. The first major finding is that prevention is a viable concept in CMHCs; however, primary prevention is perceived as a highly precarious area while secondary and tertiary levels of prevention are generally accepted. Within primary prevention, the consensus of all staff levels is that crisis intervention is most feasible, followed by institutional change and social action. Practical barriers are most cited for all primary prevention programs, while theoretical and practical barriers are equally cited for social action; in general, the focus is on expertise, staff orientation, and lack of immediate results. The data show that legislative intent will not

automatically be operationalized at the local level, especially when the program is highly decentralized in a network of CMHCs.

55. Perlmutter, F.D. Consultation and education in rural community mental health centers. *Community Mental Health Journal* 15(1):58-68, 1979.

The status of consultation and education in the rural community mental health center was investigated. Rural programs on several organizational dimensions were compared to nonrural programs. Distinctive characteristics of rural programs include ideological orientation, dominance of the medical model, problems with the grantee or auspice, and political context. A case illustration of a successful consultation education service is presented. Strategies for strengthening consultation and education in the rural setting are discussed, including clarity of structure, full-time consultation education leadership, clear program priorities, selective recruitment or training to implement these priorities, and work with the center director and board to understand and support the consultation education program. Data are based on the findings of a study of prevention programs in community mental health centers in Region III (Pennsylvania, Delaware, Maryland, Washington, D.C., Virginia, and West Virginia).

56. Perlmutter, F.D. "Prevention programs in CMH Centers." Final report, NIMH grant MH-25351. Unpublished paper, 1979. 10 pp.

Primary, secondary, and tertiary consultation and education programs within community mental health centers (CMHCs) were examined, focusing on their organization and the effects of urban versus rural catchment areas on program development. CMHCs included all federally funded centers prior to January 1973 in Region III. Responses were obtained from center directors, outpatient directors, consultation and education directors, and consultation and education staff. It was found that consultative and education programs are in early developmental stages and are struggling to define themselves while accommodating themselves to the particular setting in which they are lodged. Specific difficulties in providing primary, secondary, and tertiary prevention are discussed, and data are provided for an initial set of performance indicators and program quality standards. Technical assistance and applied research are much needed.

57. The physician-CMHC connection: Why isn't it stronger? *Behavioral Medicine* 7(11):34-37, 1980.

The low referral rate by private physicians to community mental health centers (CMHCs) is discussed. Such patients account for

less than 10 percent of all CMHC patients, and there is a need for greater liaison between private physicians and these facilities. A guideline for determining those patients who would benefit the most from the diverse and multifaceted services available in CMHCs is presented. CMHC services include outpatient, emergency, consultation and education services, as well as services for children, adolescents, and the elderly, psychiatric screening and counseling, transitional care and followup, and treatment for alcohol and drug abuse.

58. Smith, D.C. Michigan's mental health system: Community services, legal issues are key features of sixties, seventies. *Michigan Medicine* 77(23):452, 454, 1978.

The rapid material expansion of Michigan's mental health facilities in the 1960s following the passage of the State's Mental Health Services Act of 1963 is traced, and the shift in focus to patient rights, legal issues, and new treatment techniques within the State mental health program in 1970s is delineated. One important development in Michigan's mental health services in the 1960s has been the rapid acceptance by the counties of funding for consultant services, information and education services, outpatient diagnostic and treatment services, inpatient treatment, and rehabilitation services. Other actions included the establishment of specialized hospital units for children and the building of a network of community day training programs for severely mentally retarded children. In the 1970s, adjustments to issues growing out of the civil rights and consumerism movements characterized the State's mental health policies. In reaction to the declaration by the Federal courts that Michigan's commitment statute was unconstitutional, new State legislation required the Department of Mental Health to guarantee patient rights and to promote the availability of comprehensive care and treatment services for the mentally ill and the mentally retarded. The implications of new State laws for the greatly expanding number of private psychiatric facilities in the State are also discussed.

59. Soreff, S.M., and Elkins, A.M. A community mental health center's consultation service in a general hospital. *Hospital and Community Psychiatry* 28(10):749-752, 1977.

A community mental health center operates a psychiatric consultation program as an integral part of the medical emergency service of a 550-bed general hospital. A major advantage of the system is that it allows the hospital to provide immediate comprehensive services--psychiatric as well as medical--to emergency patients. The consultation program also accepts referrals of hospitalized medical patients with apparent emotional problems and

referrals of patients from such sources outside the hospital as pediatricians, clergymen, and other community agencies.

See also:

138, 290, 355, 363, 365, 445, 459, 491, 504, 628, 658, 673, 729, 733, 738, 757, 763, 808, 841.

Counseling

60. Burggraf, M.Z. Consulting with parents of handicapped children. *Elementary School Guidance and Counseling* 13(3): 214-221, 1979.

Guidelines are offered for effective counselor consultation with the parents of handicapped children. The most effective counselor is characterized as not opinionated, able to provide accurate information about resources and services, willing to seek the opinions of other professionals, able to suggest rather than command, and able to encourage parents' suggestions and observations. The primary role of parents in teaching their handicapped children is emphasized. The legal rights of parents and the school system are summarized. Information, therapeutic, and communicative consultation strategies are described.

61. Cochran, D.J. Organizational consultation: A planning group approach. *Personnel and Guidance Journal* 60(5):314-318, 1982.

Potential reasons are hypothesized for the reluctance of counselors to use preventive strategies in their interventions. An organizational consultation in a higher education setting is reviewed as a case example of a preventive intervention. A 10-step planning group model is traced as the basis for the consultation. Organizational climate data and the implications of change related to the data are presented.

62. Dinkmeyer, D., and Dinkmeyer, D., Jr. Consultation: One answer to the counselor role. *Elementary School Guidance and Counseling* 13(2):99-103, 1978.

The position of counselor consultant is discussed as an essential role in improving the educational experience of students. It is asserted that counselor consultants should apply their skills and personality to work effectively with teachers, administrators, and parents. They should be aware of the influence of school administrators on school policy, of teachers on conditions for learning, and of parents on the child's feelings of worth, value, and belonging. The counselor consultant position requires flexibility,

ability to negotiate, and an optimistic outlook. It is suggested that through consultation, school counselors can enhance their role and increase their effectiveness.

63. Drapela, V.J. Counseling, consultation, and supervision: A visual clarification of their relationship. *Personnel and Guidance Journal* 62(3):158-162, 1983.

Presents a graphic matrix--the three-dimensional intervention model--that serves as a framework to help counselors visualize the mutual relationships of counseling, consultation, and supervision. Emphasizes the need for conceptual awareness and theoretical clarity among counselors if they wish to operate as professionals rather than at the level of technicians. An integration of counseling, consultation, and supervision is necessary for the enhancement of professionalism and the increase of the overall effectiveness of counseling practitioners.

64. Hannaford, M.J. Strengths and weakness of counselor training programs: The search for direction. *Counselor Education and Supervision* 17(4):300-305, 1978.

The strengths and weaknesses of counselor training programs were studied. Results of a questionnaire administered to 32 counselors show that little or no training is reported in consultation skills, organization of programs, vocational guidance, use of materials, dealing with parents and teachers, family counseling, and leadership skills. Preparation areas which enhanced counselors' confidence during the first year of practice are chiefly in the areas of individual counseling, career counseling, tests and measurements, and facilitation skills. Results suggest that the programs left most counselors generalists with strong feelings of insecurity when faced with an actual job.

65. Hohenshill, T.H., and Humes, C.W. II. Roles of counseling in ensuring the rights of the handicapped. *Personnel and Guidance Journal* 58(4):221-227, 1979.

A description is provided of the legal rights of the handicapped, as mandated by several pieces of Federal legislation. Some important roles for counseling designed to help ensure the rights of handicapped youth and adults are also proposed, with special emphasis on such counseling roles as information, advocacy, parent counseling and consulting, career development, and individual planning. The specific Federal statutes are intended to provide education, training, social services, and employment opportunities for the handicapped and concurrently have a heavy influence on the way counselors function. (abs.)

66. Houter, K.D. Alternatives to drug treatment for hyperactivity. *Elementary School Guidance and Counseling* 14(3): 206-213, 1980.

Alternatives to drug treatment for childhood hyperactivity are discussed with emphasis on the need to devise an appropriate learning situation to meet the needs of such children. Redesigning the environment, scheduling uninterrupted time, decreasing stimulation, and fostering a democratic leadership style are presented as four new approaches. To implement these alternatives, the elementary school counselor must consult with the teacher, coordinate the system, aid in curriculum development, and assist the child in positive growth and development. These approaches emphasize the whole child as an integrated, fully functioning human being and avoid the detrimental aspects of labeling which may become a self-fulfilling prophecy of failure and delinquency.

67. Huckaby, H., and Daly, J. Impact of PL 94-142 on counselor roles: Got those PL 94-142 blues. *Personnel and Guidance Journal* 58(1):70-72, 1979.

The impact of PL 94-142, the Education for All Handicapped Children Act, on counselor roles and responsibilities is examined. It is suggested that school counselors are spending 75 to 90 percent of their time with implementation of PL 94-142. The counselor receives referrals for special education from teachers, gathers achievement data, administers necessary tests, and plays a part in case conferences, development of individual education plans, and placement. In addition, the counselor is responsible for pupils already in special education classes. Referrals for special services and career education usually fall to the counselor. Thus, counselors are involved in coordinating, counseling, consultation, and communication. Skills needed to meet these role demands are discussed, together with implications for counselor education.

68. Kameen, M.C., and Parker, L.G. The counselor's role in developing the Individualized Education Program. *Elementary School Guidance and Counseling* 13(3):189-196, 1979.

The role of the elementary school counselor in developing the Individualized Educational Program required by the 1975 Education for All Handicapped Children Act is discussed. A case study is presented as an illustration of counselor participation in development, consultation, guidance, counseling, and evaluation. It is contended that, while maintaining their traditional role with normal children, school counselors can redirect existing skills to serve disabled children.

69. LaFountain, R., and Curran, J. Referrals and consultation. *Elementary School Guidance and Counseling* 17(3):226-233, 1983.

Presents two checklists that can be used by an elementary school counselor to aid in promoting self-referrals from children: the "smiley-frowny" sheet for kindergarten through grade 2, and the "feelometer" for grades 3-6. Examples are presented to demonstrate how the checklists can alert counselors to urgent cases of referral and how they may be used in the counseling session to initiate conversation. Potential pitfalls of a teacher-counselor consultation game are discussed, and suggestions for more effective use of the consultation process are outlined.

70. Male, R.A. Consultation as an intervention strategy for school counselors. *School Counselor* 30(1):25-31, 1982.

Presents a comprehensive approach to consultation that school counselors may use when consulting with teachers, parents, administrators, and students. Consultation is viewed as an intervention strategy involving a relationship between a professional helper, a client, and a help-needing system. General goals for consultation are (1) creating an active sense of self-awareness in the consultee and target systems, (2) facilitating an appreciation for learning and understanding aimed at creating awareness, (3) making clients open to the assimilation of new information, and (4) instilling a sense of competence and confidence about the systems' adaptability and ability to manage positive change. The purchase-of-service, mediation, and collaboration modes of consultation are described. It is suggested that school counselors functioning as consultants play important roles in creating positive change and facilitating the growth and development of the clients they serve.

71. McBeath, M. Consulting with teachers in two areas: Grief and mourning; relaxation techniques. *Personnel and Guidance Journal* 58(7):473-476, 1980.

Increased encounters between counselors and teachers to help students are advocated, and two possible consultation areas, grief management and relaxation, are considered. Grief is the normal reaction to any kind of loss, and being aware of the various stages is the first step in helping someone through the grief process. Relaxation techniques can be learned with proper guidance. The need for sufficient information and training in applying new ideas is noted.

72. McIntosh, D.K.; Minifie, E.L.; Rotter, J.C.; Salmond, T.; and Turner, K. PL 94-145 and the elementary school counselor: An interview. *Elementary School Guidance and Counseling* 13(3):152-163, 1979.

Interviews of educators and school personnel are presented in order to provide perspectives on the role of elementary school counselors under the Education for All Handicapped Children Act. The act requires that handicapped children be provided a free education equal to that of normal school children. The issues of counselor training in special education, counselor roles, and future trends are addressed. Among the counselor roles suggested are prevention of difficulties in mainstreaming and integration, consultation with special educators regarding the affective needs of handicapped children, noncrisis developmental counseling, provision of a comprehensive variety of services, and consultation to parents and teachers of handicapped children.

73. Mirelowitz, E.R. Case analysis: A changing family system. *Elementary School Guidance and Counseling* 13(2):135-140, 1978.

The process used by a teacher and a counselor to develop a working relationship with the mother of a 7-year-old boy who was experiencing difficulty after the birth of a baby sister is described. The roles of the teacher and counselor in recognizing the problem and working toward a resolution are explained. Teacher-student, teacher-counselor, and counselor-parent interactions are described. A group counseling session for children was conducted to increase feelings of self-awareness and acceptance for the child. It is suggested that counselors need to develop effective consultation skills in working with parents and teachers in order to gain their cooperation in implementing changes to help the child.

74. Moyer, P.C., and Hysler, S.B. Children on drug therapy: Counselors can help. *Elementary School Guidance and Counseling* 14(3):196-204, 1980.

Guidelines for providing counseling services to children experiencing health problems requiring drug therapy are reviewed. These services include (1) identifying special needs of specific children, their families, and teachers; (2) providing psychological and technical support for children, families, and teachers; and (3) promoting school responsiveness to the health problems and needs of individual pupils. The counselor must act to promote self-awareness and self-development among these students; effective techniques include individual and group counseling with children, consultation with teachers and parents, and conferences involving various combinations of the above groups. A case study is included to

demonstrate how the counselor can help the child and significant others cope with the demands of the health condition and accompanying drug therapy.

75. Van Hesteren, F. Staff-group consultation within a developmental framework. *Canadian Counsellor* 14(4):223-229, 1980.

Provides ideas and guidelines for counselors interested in functioning as consultants within a developmental framework. A nine-step inservice model suited to developmental consultation is presented. A developmentally focused inservice workshop is described, and evaluation of developmentally oriented inservice work is discussed.

76. Washburn, H.R. Getting started with teacher groups. *Elementary School Guidance and Counseling* 13(1):56-64, 1978.

Three models for teacher group counseling, the teacher support group, student centered consultation, and the organization development approach are presented. A general overview of each model and its unique purposes, content, organization, and structure are discussed. The counselor skills necessary for implementation of each model are covered. Ideas for the apprehensive counselor in getting started with teacher groups are given. The implications of group consultation for those involved in such processes are considered.

77. Westling, D.L., and Joiner, M.D. Consulting with teachers of handicapped children in the mainstream. *Elementary School Guidance and Counseling* 13(3):207-213, 1979.

The influence of mainstreaming on the role of school counselors is examined. Counseling approaches for consultation with teachers of handicapped children are described. The implications of attitudes of school personnel toward the practice of mainstreaming, the lack of objective evaluations of mainstreaming, and the need for counselors to obtain more knowledge about handicapped children are discussed. It is suggested that the counselor begin working with the teachers who are most receptive to mainstreaming. The counselor can serve as an intermediary between regular and special educators regarding the delineation of responsibilities. The monitoring of behavioral change is viewed as an important intervention role for the school counselor.

78. Wilson, N.H., and Rotter, J.C. Elementary school counselor enrichment and renewal. *Elementary School Guidance and Counseling* 14(3):178-187, 1980.

The phenomenon of change is examined as it relates to elementary school counselors, to their evolving role and complementary training needs. Emphasis is on a study of the present professional continuing education needs of South Carolina counselors. A survey in this State revealed the following priority training needs of elementary school counselors: classroom guidance, group counseling, self-concept development, legal issues, mainstreaming, consulting skills, crisis intervention skills, communication skills, family counseling, parent education, curriculum input, and understanding child growth and development. It is concluded that these expressed needs must be met by specific renewal activities in colleges, universities, and other training facilities.

79. Zieziula, F.R. Counseling deaf children: A new art. *Personnel and Guidance Journal* 58(4):287-289, 1979.

Basic knowledge and skills necessary for counseling deaf and hearing impaired children, a service that is likely to be a responsibility of most school counselors as a result of PL 94-142, are discussed. The training program for such professionals at Gallaudet College is also described. Key elements in the program include techniques for overcoming the lack of verbal communication skills, psychometric and psychological assessments, interpersonal relations training, studies of the thinking patterns in deaf persons, and knowledge of educational opportunities available for deaf students. The major focuses of the training are on consulting with teachers and parents and on guidance activities designed to encourage the development of coping skills, problem solving abilities, and positive self-concept in deaf children. (abs.)

See also:

342, 478, 479, 484, 495, 505, 581, 629, 643, 655, 661, 663, 674, 685, 735, 768, 769, 777, 786, 811.

Education

80. Childs, R. The role of the resource teacher in special education. *Journal for Special Educators* 16(1):84-88, 1979.

The role of the resource teacher in providing special education to mainstreamed mentally retarded children is examined. It is contended that little agreement exists regarding this role, and the suggested functions put forward in the literature are briefly reviewed. These include offering direct services to the classroom

teacher, provision of experimental education, and consultation in classroom diagnosis and assessment, and problem solving.

81. Gilhool, N., and Ginn, R. Meeting the needs of a child with mild learning problems. *Journal of Learning Disabilities* 15(5):299-302, 1982.

The diagnostic-prescriptive teacher program is an organizational model designed to provide help within the regular classroom for children with mild learning problems. The key to the program is the diagnostic-prescriptive teacher, a school-based specialist who combines diagnostic and consultative work in assisting the regular classroom teacher. The rationale, advantages, and distinctive characteristics of the program are outlined and procedures used are described in detail. The program is compared with other models currently used to provide services to children with mild learning difficulties--special education, itinerant specialists, and use of existing staff.

82. Lilly, M.S., and Givens-Ogle, L.B. *Behavioral Disorders* 6(2):73-77, 1981.

Analyzes forces that have brought about increased emphasis on teacher consultation by special educators. Consultation is defined, and a historical overview of teacher consultation activities in special education is provided. Future issues in consultation are delineated with particular emphasis on needs in the areas of research and teacher education.

83. Litton, F.W., and Ouder, C.C., Jr. Parental involvement in the education and training of retarded children. *Journal for Special Educators* 15(3):222-227, 1979.

The increase in parental involvement in the education and training of retarded children during the last few years is noted, and information for special educators consulting with parents of retarded children is discussed. The concept of parents as teachers in the home or serving as volunteers in the school is discussed, and the needs of parents of mentally retarded children for understanding, counseling, and guidance are described. Specific suggestions for more efficient and effective parent training programs are offered and resources for parents are cited.

84. Miller, T.L., and Sabatoin, D.A. An evaluation of the teacher consultant model as an approach to mainstreaming. *Exceptional Children* 45(2):86-91, 1978.

Contrasted are two special education resource service models for their effects on student achievement and on teacher and pupil

behavior. A total of 547 mildly handicapped children (mean age 8.4 years) participated in the study--261 subjects in the teacher consultant model, 219 in the resource room model, and 67 controls. Dependent measures of academic achievement were the Word Recognition and Arithmetic subtests of the Wide Range Achievement Test and the Reading Comprehension subtest of the Peabody Individual Achievement Test. Academic performance gains were equivalent for both models, while teacher behaviors were judged slightly better under the teacher consultant model. Both approaches were superior to controls (no service). The parallel academic gains coupled with improved teacher behaviors suggest the utility of having both models in operation within a continuum of services. Data support increased instruction in the regular classroom, thereby promoting many of the goals of mainstreaming through education in the least restrictive environment, improved regular teacher skills, and attenuation of the effects of labeling. (abs.)

85. Taylor, L., and Adelman, H. Demonstration and research programs for learning problems at Fernald, UCLA. *Journal of Learning Disabilities* 13(7):392-397, 1980.

Demonstration and research programs at Fernald, a major training and research center at the University of California at Los Angeles, in the area of learning problems are reviewed. Current experimental models at Fernald focus on innovative approaches to planning, implementing, and evaluating programs of assessment and consultation, instruction, and psychological and educational therapy. The sequential and hierarchical model of intervention utilized in Fernald's motivational and developmental programs is assessment leading to the establishment of a personalized program designed to provide learning opportunities that accommodate the client's interests and developmental level. Only if this personalized program proves insufficient are specialized interventions planned in a collaborative fashion by the intervener and the client. Such interventions may require specialized teaching, counseling/psychotherapy, neurological evaluation, and/or medical (nutritional, drug) treatment. Assessment of the treatment is an ongoing process. In addition, Fernald offers client assessment and consultation programs in which consultants work with parents and pupils in decisionmaking and problem solving relevant to psycho-educational needs. Transition programs aid clients and families prior to and during the adjustment period of entry into other service programs.

86. Vance, B.; Roberson, J.; and Hanson, D. James Madison University's Child Development Clinic. *Journal of Learning Disabilities* 13(7):400-403, 1980.

Treatment and training functions of the Child Development Clinic of James Madison University are described. The clinic is a regional diagnostic center that offers remedial and counseling services to a wide variety of handicapped children and youth. Services are combined with training of graduate students and staff within various university departments including special education, school psychology/counseling, speech, hearing, and reading. Cases referred by physicians, schools, parents, and agencies are monitored and assigned to students who consult with the director and the professional staff. Three major areas of service are provided: comprehensive psychoeducational assessment and diagnosis; interventions in the areas of parenting, counseling, remedial reading, special education, language development and speech, and development of individualized education plans; and a wide range of consultation services. The value of such an experimental and interdisciplinary training program is emphasized.

See also:

487, 561, 597, 634, 764, 775.

Medicine

87. Boyce, W.T.; Sprunger, L.W.; Duncan, B.; Sobolewski, S. A survey of physician consultations in an urban school district. *Journal of School Health* 53(5):308-311, 1983.

Conducted a survey of physician encounters in an urban school district following the institution of consultative, rather than full-time, school physician services. Encounter forms were completed on 140 consultations over 6 months. Results show that (1) most consultations related to the problems of individual children, (2) there was a high prevalence of behavioral and psychosocial problems, and (3) physicians were prominently involved in cross-disciplinary interactions.

88. Fitzgibbons, P.M., and Ferry, P.C. It's the law: Mandatory public education for handicapped children. *American Journal of Diseases of Children* 133(5):476-478, 1979.

Public Law 94-142, which requires public education for handicapped children, is examined in terms of the historical events which led to its passage, its major components, and its implications for pediatricians. The stated purpose of the act is to ensure

that all handicapped children have available to them a free appropriate education and related services designed to meet their unique needs. It is recommended that pediatricians become familiar with implementation plans in their State; become involved in the identification of children who have a disability which may require special services; be knowledgeable about key educational personnel and be available to those personnel for consultation; obtain information regarding the local evaluation process and assist in this process where possible; counsel parents about the nature of the problem their child has and their rights and options in obtaining appropriate schooling for the child; and become involved in local advocacy groups and local educational policy-making organizations. The physician is often the first person consulted when a child has special problems, and his involvement in education helps to improve the educational management of these children.

89. Palfrey, J.S.; Mervis, R.C.; and Butler, J.A. New directions in the evaluation and education of handicapped children. *New England Journal of Medicine* 298(15):819-824, 1978.

Some of the many implications for physicians of the Education for All Handicapped Children Act of 1975 (PL 94-142), which went into effect in October 1977, are examined. Though the role for the physician is implied rather than defined in the law and physician involvement will vary from State to State, they will at a minimum be involved with counseling parents whose children are under evaluation. Requests from local educational agencies for consultation will pose several issues: (1) whether formal screening programs are better than less formal clinical observations, (2) whether it is more efficient to focus identification efforts on "at-risk" populations than on the child population in general, (3) how predictive early indicators are of later performance in view of the relatively new concept of early identification in the education field, and (4) whether early diagnostic capability should be based in the schools at all. The role of individual State regulations in the formation of the individualized education program for each child is described. It is noted that State special education statutes will largely define physician involvement in this sphere of the program. The "least restrictive environment" provision of PL 94-142 and the role of the physician are discussed in relation to educational services to the handicapped child. The physician's relationship to the parents of the handicapped child is assessed. It is concluded that a special burden is placed upon physicians to develop better assessment tools in diagnosing handicapped children and to establish good communication links with special educators. (abs.)

90. Schmitt, B.D. Current pediatric roles in child abuse and neglect. *American Journal of Diseases of Children* 133(7): 691-696, 1979.

Levels of involvement of pediatricians in the problem of child abuse and neglect are reviewed. It is argued that the practicing pediatrician must consider the diagnosis of child abuse and neglect, confirm the diagnosis, report all suspected cases to child protective services, hospitalize any abused child who needs protection, and provide preventive services. The hospital-based child abuse consultant's role consists of providing consultation to primary physicians, reporting seriously injured cases for the primary physician or surgeon, providing expert medical testimony on difficult-to-prove cases, teaching house staff and medical students about child abuse and neglect, and improving treatment services for hospitalized abused children. The work of the child protection team pediatrician is described. (abs.)

91. White, H.M. The medical and psychological problems of retirement. *Practitioner (London)* 221(1321):97-101, 1978.

The pitfalls and advantages of retirement are examined from the viewpoint of the general practitioner who must deal with the medical and psychological problems of aging. The importance of continued social involvement is discussed, suggesting that activities with a group of retired contemporaries or participation in community service projects can be personally rewarding. Some individuals require association with other age groups and desire part-time employment. There is a growing pressure for general practitioners to participate in health education, and group sessions with elderly patients can be rewarding. Areas of consultation and advice that are frequently encountered in such groups or in counseling individual patients are described.

See also:

330, 498, 499.

Nursing

92. Andrianos, A.F., and Swain, C.R. Interfacing the role of a psychiatric clinical nurse specialist with a hospital emergency room setting. *Journal of Psychiatric Nursing and Mental Health Services* 17(4):24-27, 1979.

The role, function, and duties of the psychiatric clinical nurse specialist in the hospital emergency room setting are delineated. The purpose of the psychiatric clinical nurse specialist is to facilitate psychiatric services in the emergency room through

consultation with emergency personnel. Duties involve assessment and treatment of psychiatric patients, coordination of psychiatric admissions in the emergency room and referral to the hospital unit or other community agencies, handling of referral contacts from physicians and agencies in the community and provision of followup, consultation to nursing and medical staff at both the hospital and in the psychiatric outpatient clinic, research or demonstration projects, and supervision of mental health students.

93. Baldwin, C.A. Mental health consultation in the intensive care unit: Toward greater balance and precision of attribution. *Journal of Psychiatric Nursing and Mental Health Services* 16(2):17-21, 1978.

Mental health consultation for families, patients, and staff as an aid in dealing with the psychological pressures arising in the intensive care unit (ICU) is examined with reference to the selection of a therapy model. Interpersonal therapy is recommended due to the natural tendency in patients and staff to communicate with each other arising from the tension and uncertainty in the ICU. The balance attribution theory proposed by Heider is studied with relation to its meaning for the ICU. Heider's theory acknowledges the roles of individuals, of persons interacting, and of the nonpersonal and high pressure environment in the attribution of a person's actions. The goals for mental health consultation would, according to this model, be the success of all participants in dealing with their common environment as flexibly as possible.

94. Barbiasz, J.; Blandford, K.; Byrne, K.; Horvath, K.; Levy, J.; Lewis, A.; Matarazzo, S.P.; O'Meara, K.; Palmateer, L.; and Rossier, M. Establishing the psychiatric liaison nurse role: Collaboration with the nurse administrator. *Journal of Nursing Administration* 12(1):14-18, 1982.

By helping patients, families, the hospital staff deal with the emotional effects of illness, the psychiatric liaison nurse plays a significant role in patients' healing. Since this type of role may be new to the organization, the psychiatric nurse and the nursing administrator must work in tandem to ensure successful role development and entry into the hospital system, both of which are crucial to the effectiveness of the liaison nurse. In our clinical experience, these issues need careful consideration and attention by both nurse administrators and psychiatric liaison nurses. We have attempted to provide practical considerations for facilitating the success of a psychiatric liaison nurse in the hospital system and justifying the value of this role.

95. Berarducci, M.; Blandford, K.; and Garant, C.A. The psychiatric liaison nurse in the general hospital: Three models of practice. *General Hospital Psychiatry* 1(1):66-72, 1979.

The creation and implementation of the role of the psychiatric liaison nurse in three general hospitals are described. The historical evolution and theoretical bases of the role are reviewed, as well as the specific reasons for creation of such a role in each of the three hospitals. Three typical patient consultations by liaison nurses illustrate the need for provision of such services within the general hospital. Similarities in the implementation of the role of liaison nurse in the three hospitals are discussed. (abs.)

96. Covert, A.B. Community mental health nursing: The role of the consultant in the nursing home. *Journal of Psychiatric Nursing and Mental Health Services* 17(7):15-19, 1979.

The role, effectiveness, and efficacy of the nurse consultant with regard to the development of comprehensive psychiatric services for nursing home clients are discussed. There are multiple patient-related factors which make geriatric nursing a specialty unto itself, including sociocultural values associated with aging. The consultant must make workable recommendations of value to both client and staff and consistent with the nursing home's policy. A mental health consultant nurse must demonstrate that psychiatric consultation can be practiced by nursing home staff.

97. Davis, D.S., and Nelson, J.K.N. Psychiatric liaison nursing at Yale-New Haven Hospital. *Connecticut Medicine* 42(11): 721-723, 1978.

The role of psychiatric liaison nursing specialists (PLNs) at a large Connecticut teaching hospital is described. The role has evolved in response to the needs of particular institutions and involves liaison with a number of medical and surgical units where the PLNs function in clinical roles without administrative responsibilities. The PLN as a consultant is a resource for the staff nurse to help her understand the psychosocial needs of patients and to differentiate normal from abnormal responses to the stresses of physical illness and hospitalization. The PLNs also work closely with psychiatrists and second year psychiatric residents. Academic requirements include master's degrees in psychiatric nursing. A brief description of a typical working day is provided to illustrate the usefulness of expert consultation and the increasing emphasis within the medical profession on the role of psychological factors in health and illness and the importance of treating the whole person.

98. Dilts, S.L.; Berns, B.R.; and Casper, E. The alcohol emergency room in a general hospital: A model for crisis intervention. *Hospital and Community Psychiatry* 29(12): 795-796, 1978.

The alcohol emergency room at Denver General Hospital is discussed as a model for crisis intervention for alcoholics. The unit is staffed 24 hours a day by nurses. Patients spend an average of 45 minutes in triage. About half of the patients require inpatient treatment and the others are referred to outpatient programs. Unit staff emphasizes consultation and liaison with other hospital staff to coordinate the treatment system and provide education on aspects of alcoholism. They also explain the patient's condition and needs to the patient's significant others, who provide crucial external support. The program staff currently sees about 400 patients and answers about 270 telephone requests for information about alcoholism treatment monthly. (abs.)

99. Dimond, B. The right to be consulted. *Nursing Mirror* 5(14):34-35, 1983.

This article outlines the nurse's role in the treatment of the mentally disordered, in light of the 1983 Mental Health Act in England. The 1983 Act places treatment into three categories with special provisions for each; each category and how nurses must be involved within it are discussed. Also presented are some of the related ethical and legal issues not clearly covered by the Act.

100. Fife, B. The challenge of the medical setting for the clinical specialist in psychiatric nursing. *Journal of Psychosocial Nursing Mental Health Services* 21(1):8-13, 1983.

The purpose of sharing these ideas about the role of the psychiatric clinical specialist in the medical setting has been threefold: (1) to stimulate the interest of others by communicating the needs for and the value of such a role in improving health care; (2) to convey the variety of potential opportunities available in the role; and (3) to share some ideas about specific activities which can be pursued in such a role. The clinical specialist who chooses to work in the medical setting will discover opportunities to develop creativeness, to explore innovative ideas, and to utilize the variety of one's personal resources and past learning experiences. It affords opportunities to serve as a change agent, to influence the quality of patient care, and to stimulate the growth of other nurses. It allows for ongoing contact and exchange with other professional groups comprising the health care team. Finally, it provides the nurses with a high level of autonomy and challenge in defining their own roles.

101. Fife, B., and Lemler, S. The psychiatric nurse specialist: A valuable asset in the general hospital. *Journal of Nursing Administration* 13(4):14-17, 1983.

In summary, what are the ways in which the psychiatric/mental clinical specialist contributes to cost-effectiveness, professional growth of nursing staff, and quality patient care in the general hospital setting? All services of the psychiatric/mental health clinical specialist are ultimately directed toward increasing the effectiveness with which staff can deliver care. This goal is accomplished by helping staff nurses maximize their knowledge, by providing needed educational opportunities, by promoting the use of a holistic model of care, and by helping staff cope with their own stress. In our experience, high quality care that meets the physiological needs of patients decreases the length of the hospital stay, prevents repeated hospitalizations, and minimizes the development of psychosocial problems secondary to the illness. With the necessary support and cooperation from administration, this clinical specialist role reduces health care costs, promotes a higher level of functioning in patients and their families, and increases the level of job satisfaction for the staff who provide direct bedside care.

102. Jaffe, S. Innovative pathways for alcoholism consultation. In: American Nurses' Association. *Clinical and Scientific Sessions*. Kansas City, Mo.: the Association 1979. pp. 305-318.

The role of the nurse clinical specialist on the alcoholism consultation team of an alcoholism treatment program involving inpatient, outpatient, and outreach components is described. Collaboration through team effort is used to develop strategies to promote interest in alcoholism and to change staff attitudes and improve the care of the alcoholic and his family through staff-patient and team-patient interaction, coordinated treatment planning, and the staff education. The model of collaboration is one of planned change which recognizes the holistic, dynamic, and collaborative relationship necessary to improve operations of a human system. Activities undertaken during consultation, problems encountered, strategies for meeting special patient and staff needs, and goals and outcomes are discussed. Through expansion of the nurse clinical specialist role to include expertise in chemical dependency, innovative pathways can emerge to help identify and discriminate patterns of chemical usage that are creating potential or actual problems in a variety of settings for a variety of individuals in need of help.

103. Jansson, D.P. Student consultation: A liaison psychiatric experience for nursing students. *Perspectives in Psychiatric Care* 17(2):77-82, 94, 1979.

A pilot project at Evanston Hospital School of Nursing, offering an experience in liaison psychiatry for psychiatric nursing students, is described. A developmental model, adapted from Freedman, provides a framework for the consultative process. The concepts of adaptation, regression, and anxiety were chosen to aid understanding of the interrelationship of physical and psychological states. During the pilot project, 50 students completed the psychiatric nursing module. To a great extent project objectives were achieved: students were able to effectively act as resources to one another and to use these experiences for further learning. In addition, consultations were requested in medical, surgical, rehabilitation, oncology, and intensive care units, forging a link between psychiatric and medical services.

104. Krauss, J.B. The chronic psychiatric patient in the community. A model of care. *Nursing Outlook* 28(5):308-314, 1980.

A model of comprehensive community support and care for the chronic deinstitutionalized psychiatric patient and his or her family is presented with emphasis on the role of the nurse in meeting the needs of this population. Trends toward increasing deinstitutionalization and greater utilization of community mental health service delivery models are discussed. Studies of discharged patients have indicated that such patients tend to be deficient in social and living skills, socially isolated and withdrawn, lacking in employment skills, and frequently do not receive adequate outpatient and followup services. Studies have also demonstrated the great impact of the deinstitutionalized patient on the family, yet families appear to be receiving little in the way of supportive guidance. Countering these negative aspects of deinstitutionalization requires comprehensive and coordinated intervention efforts in the areas of education, self-help, extended support, and supportive therapy. The importance of the family in community maintenance of the patient, the need for a formal crisis intervention system, rehabilitation, and the role of the psychiatric nurse in coordination of services through liaison and consultation are emphasized.

105. Lambert, C.E., Jr., and Lambert, V.A. Nursing students and a mental health consultation program. *Journal of Psychiatric Nursing and Mental Health Services* 19(3):29-35, 1981.

A mental health consultation program for undergraduate nursing students was planned, implemented, and evaluated. The program

emphasized the need for nurses to understand the psychosocial needs of patients who sustain physical illness and are placed in the acute care setting. It also provided a learning experience for graduate psychiatric/mental health nursing students in the pre-planning phase of the program, encouraging graduate students to negotiate their roles as consultants and to establish their own criteria for self-evaluation, delineation of outcome measures, and the need for a physical location for consultation.

106. Levenson, J.L., and Levy, N.B. Nurses and psychiatric liaison. *Psychosomatics* 23(3):295-299, 1982.

The authors respond to an article by Z.J. Lipowski in the September 1981 issue of *Psychosomatics*: "New Prospects for Liaison Psychiatry." They disagree with Lipowski's views on the role that a liaison nurse should take in the consultation-liaison psychiatry process.

107. Palermo, E. Mental health consultation in a home care agency. *Journal of Psychiatric Nursing and Mental Health Services* 16(9):21-23, 1978.

Personal experience is cited to demonstrate that a mental health nurse who is educationally and clinically prepared as a specialist can be effectively utilized as a consultant to aid nurse generalists in assessment and intervention with patients in a home health care agency. An individual staff nurse consulting with the specialist or a group of nurses provides the setting for consultant-led case discussions. Consultation is a highly efficient use of a specialist's knowledge and skills in health care delivery and also provides learning opportunities for staff. (abs.)

108. Palmateer, L.M. Consultation and liaison implications of awakening paralyzed during surgery: A syndrome of traumatic neurosis. *Journal of Psychosocial Nursing and Mental Health Services* 20(11):21-26, 1982.

The traumatic neurotic syndrome that occurs upon awakening paralyzed during surgery is a clinical problem unique to the medical setting. It presents the liaison nurse with potential problems in assessment. Given the patient's hesitancy to discuss the experience, the existence of this syndrome always should be considered when evaluating a highly anxious post-operative patient. Beyond the problems of patient assessment, this syndrome can represent a complex consultation-liaison problem, especially for a staff unfamiliar with its existence. A review of the concepts of consultation-liaison work often identifies problematic areas (such as interdisciplinary cooperation and educational needs) that the consultant should cover. The case presentation and discussion

illustrate the process of applying consultation liaison principles to a complex clinical problem unique to the medical setting--the traumatic neurotic syndrome that occurs as a result of awakening paralyzed during surgery.

109. Pisarcik, G.; Zigmund, D.; Summerfield, R.; Mian, P.; Johansen, P.; and Deveraux, P. Psychiatric nurses in the emergency room. *American Journal of Nursing* 79(7): 1264-1266, 1979.

The involvement of psychiatric nurses in a Boston hospital emergency room is discussed. It is argued that nurses best fill the need for psychiatric services because they are familiar with the hospital setting and are comfortable working within the health care system. Six nurse practitioners cover the emergency room on a 24-hour basis using a role model which has four broad functional categories: assessment, direct patient care, coordination and collaboration, and teaching and consultation.

110. Przepiorka, K.M., and Bender, L.S. Psychiatric nursing consultation in a university medical center. *Hospital and Community Psychiatry* 28(10):755-758, 1977.

A program of psychiatric nursing consultation was established at a large university medical center in response to requests from nonpsychiatric nurses; they generally felt that patient evaluations provided by the psychiatry liaison service did not have specific application to nursing care. The program is operated by two part-time coordinators who train and supervise the nurse consultants through monthly group sessions and individual supervision. One aim is to set up ongoing consultative meetings with nursing staffs who request help, rather than providing only one-time or crisis consultation. During the program's first year, 146 consultations were given, and an average of 9.5 nursing units received consultation services each month.

111. Robinson, L. Psychiatric liaison nursing 1962-1982: A review and update of the literature. *General Hospital Psychiatry* 4(2):139-145, 1982.

Psychiatric liaison nursing, first conceptualized in the early sixties, evolved from a perceived need to address the psychosocial problems experienced by patients who were hospitalized for treatment of physical illness. Early practitioners tended to be educators and clinical supervisors who collaborated part time with psychiatric liaison services associated with departments of psychiatry. Papers of the later sixties and early seventies described role models and delineated hierarchy, accountability, function, and supervision. The mid-seventies yielded a proliferation of

position descriptions and the introduction of educational programs to prepare psychiatric liaison nurses at the master's level. The late seventies and early eighties have seen some elaboration of theory-based practice and further evolution of the liaison role.

112. Ross, D.C.; Meinster, M.C.; and Gingrich, L.J. A program for expanding the mental health function of the school nurse. *Journal of School Health* 48(3):157-159, 1978.

A program to prepare school nurses to assume a more comprehensive and responsible role in the health care delivery system is described. Seminars were conducted in several Philadelphia private schools to train the nurses in collecting the appropriate data on which to base a diagnosis. The nurses were found to be suited to this task, and their skills adaptable to psychological information. In addition, the nurses played a consulting role throughout referral and treatment. As a result of the program, the nurses have developed school mental health practices in which they cooperate with other practitioners and school principals in the management of the children's treatment.

113. Spry, B. Organization development and the developmentally disabled: The accreditation of a work experience facility. *Mental Retardation* 16(5):350-354, 1978.

Presents an interpersonal interaction that evolved from the consultation and organization roles of a community mental health nurse. The primary goal of the director of the facility was to quickly elicit the maximum amount of cooperation from the staff in order to be adequately prepared for an on-site inspection by the Commission on Accreditation of Rehabilitation Facilities. The consultant led staff consultation sessions, gave one-to-one consultation to the director, and held individual interviews with other administration personnel.

114. Stickney, S.D., and Hall, R.C.W. The role of the nurse on a consultation-liaison team. *Psychosomatics* 22(3):224-235, 1981.

The authors report on the role and functions of a nurse-consultant on an expanding psychiatric consultation-liaison service.

115. Weinstein, L.J.; Chapman, M.M.; and Stallings, M.A. Organizing approaches to psychiatric nurse consultation. *Perspectives in Psychiatric Care* 17(2):66-71, 1979.

Three formats for successful psychiatric nurse consultation to medical-surgical units are discussed: (1) regularly scheduled group meetings in which nursing staff is able to discuss problems

and concerns; (2) crisis intervention consultation on a time-limited and on-call basis as need arises; and (3) walking on Kardex rounds in which the psychiatric nurse consultant meets with nursing staff to discuss each patient. Each program approach can meet specific needs of the unit. The need for the consultant to be both available and flexible in the goals of improving patient care and reducing anxiety among nursing staff is emphasized.

116. Wolff, P.I. Psychiatric nursing consultation: A study of the referral process. *Journal of Psychiatric Nursing and Mental Health Services* 16(5):42-47, 1978.

Factors contributing to surgical nurses' decisions to seek consultation for their patients from a psychiatric nurse consultant were investigated. A psychiatric nursing consultation questionnaire was administered which provided data on nurses' observations of and reactions to patient behavior. Patients who were referred for consultation tended to exhibit more psychopathology and elicit more negative reactions from nurses. It was found that observations of patient behavior were the most significant factor in the referral process, and that nurses' reactions did not play a significant role in referral.

See also:

34, 167, 168, 470, 529, 540, 681.

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117. Alby, J.M.; Ferreri, M.; and Gineste, T. The "liaison" psychiatrist in the general hospital. *Annales Medico-Psychologiques* 138(6):754-763, 1980.

Examines the tasks, goals, and competencies of psychiatrists acting as liaisons between psychiatric wards and general wards in French hospitals. Liaison psychiatrists (LP) visit patients in the nonpsychiatric wards at the demand of medical experts, especially if only short-term assistance is required. The double goals of LP are to help the patient fulfill his or her needs and to educate general personnel in psychiatric aspects of medical treatment. In therapy, special emphasis is placed on reducing patients' feelings of isolation and lack of control and conflicts created by illness-related anxieties. To understand medical requests, the LP must have a broad medical knowledge and the ability to communicate effectively with medical experts in nonpsychiatric wards.

118. Allen, A. Psychiatry and the oncology unit. *Psychiatric Journal of the University of Ottawa* 4(3):213-216, 1979.

Possibilities for psychiatric participation in an oncology unit are described. It is shown that the psychiatrist can be a valuable resource person in the planning and structuring of the unit, contribute through the provision of formal didactic cognitive instruction to the staff, and provide a role model for the unit staff and their approach to understanding patients. The avenues through which this can be achieved involve direct consultation with families, consultation about families, and through providing the opportunity for coping sessions with the staff. The psychiatrist can also contribute by using so-called useless consultation requests in allaying the anxiety and guilt of the attending staff. (abs.)

119. Anderson, R.G., Jr.; Robinson, C.; and Ruben, H.L. Mental health training and consultation: A model for liaison with clergy. *Hospital and Community Psychiatry* 29(12): 800-802, 1978.

A program developed by a chaplain, a psychiatrist, and a social worker to train clergy in more effective mental health care management, counseling, and referral skills, and to sensitize mental health professionals to the work of the clergy in mental health is discussed. The program consists of 12 2-hour meetings conducted by a clinician and a chaplain. In the first four meetings, clergy are trained to use a self-report personal data kit with individuals presenting emotional problems. In the next eight meetings, clergy make case presentations that are used as a basis for consultation and group discussion. The project has trained many clergymen in a process of case management that adds a new dimension to their pastoral work and has established a firm basis for collaboration between clergy and mental health center staff in providing care. (abs.)

120. Arana, G.W. The impaired physician: A medical and social dilemma. *General Hospital Psychiatry* 4(2):147-153, 1982.

Discusses the problem of psychological impairment in physicians, highlighting the prevalence of alcoholism, drug abuse, and suicide. A research review indicates that the training period is especially stressful and can precipitate depression, anxiety, and substance abuse. Those most prone to develop impairment have a significantly higher incidence of early life deprivation and adjustment problems. Physician suicide is correlated significantly with age, divorce, physical and mental illness, and abuse of both drugs and alcohol. Difficulties encountered in the treatment of emotionally disturbed physicians include their avoidance of help-seeking behavior, resistance to evaluation and treatment, and the complexities

of family and employee response to their behavior. The potential role of consultation-liaison psychiatrists in dealing with impaired physicians is discussed.

121. Barsky, A.J. III. Defining psychiatry in primary care: Origins, opportunities, and obstacles. *Comprehensive Psychiatry* 21(3):221-232, 1980.

The origins, content, difficulties, and opportunities of primary care psychiatry (PCP) are considered. Emphasis on comprehensive health care, consumerism, and, within psychiatry, the medical model, psychopharmacology, and liaison/consultation models of service delivery provided an impetus for PCP. Content and curriculum areas for PCP include psychological, interpersonal, and behavioral problems of general medical practice such as treatment compliance, maintenance and prevention, and recovery and rehabilitation processes; the medical care process including patient-physician interactions, nonspecific healing forces, psychological reactions to disease, and health care team functioning; general psychiatry in the areas of human development, psychiatric disorders and emergency, psychopharmacology, and intervention techniques; and social and cultural aspects of illness including illness roles, attitudes and beliefs, stress effects, and social support systems. A review of the literature indicates that the field is still in its infancy and needs a clearer ideology and consensus on knowledge and skills. Research opportunities are also reviewed.

122. Barsky, A.J., and Brown, H.N. Psychiatric teaching and consultation in a primary care clinic. *Psychosomatics* 23(9):908-921, 1982.

The authors report on their experience as members of a primary care team in an outpatient municipal hospital setting in which six major presenting problems in consultation requests were identified: functional complaints, noncompliance, depression, chronic psychosis, alcoholism, and physician role conflicts. It is concluded that consulting psychiatrists should have special expertise in several specific clinical areas that are common in primary care practice.

123. Beresford, T.P. Alcoholism consultation and general hospital psychiatry. *General Hospital Psychiatry* 1(4):293-300, 1979.

The relationship between consultation/liaison psychiatry and alcoholism treatment in the general hospital setting is explored. A series of cases is presented which illustrate problems and issues in alcoholism consultation. A review of alcoholism prevalence studies in surgical and medical wards of general hospitals is

presented which indicates prevalence rates ranging from 8.7 to 55 percent and emphasizes the magnitude of the problem. Finally, the role of consultation/liaison psychiatrists in diagnosis, management, and treatment referral of alcoholic inpatients is discussed. (abs.)

124. Beresford, T.P. The dynamics of aggression in an amputee: A case report. *General Hospital Psychiatry* 2(3):219-225, 1980.

A case is presented of a patient seen in consultation for an elective amputation. The approach to this situation involved a process of negotiation between the orthopedist and patient. Since the patient absolutely refused less radical procedures and insisted on amputation, the psychiatrist advised the orthopedist to proceed in the most conservative course the patient would allow. The consultant likewise suggested a course of psychotherapy for the patient to help him with his relationships. The working diagnosis was personality disorder of the schizoid type. The amputation, monosymptomatic hypochondriacal delusions, and the dynamics of aggression are discussed. (abs.)

125. Bernstein, R.A. Liaison psychiatry: A model for medical care on a general hospital psychiatric unit. *General Hospital Psychiatry* 2(2):141-147, 1980.

The need for liaison psychiatry on the inpatient psychiatric unit in a general hospital was examined by assessing the care requirements of 563 patient consultations. To utilize these consultations most effectively, the role best suited for the psychiatrist was that of liaison consultee. Case examples are used to demonstrate the effectiveness of employing liaison skills in the treatment of somatic problems on the inpatient psychiatric unit. (abs.)

126. Bernstein, S.B. Psychotherapy consultation in an inpatient setting. *Hospital and Community Psychiatry* 31(12): 829-834, 1980.

Evaluation of an ongoing psychotherapy by a consultant in an inpatient setting is shown to be a demanding and important task. In many cases consultation is best carried out in a hospital setting; the patient benefits by the structured environment and the therapist gains the support of the inpatient consultative team. Close cooperation among patient, therapist, and inpatient staff can help revitalize a psychotherapy by renewing the commitment of therapist and patient to work together again on an outpatient basis. Consultation can also lead to a decision to terminate therapy. Psychotherapy consultation should be viewed not as a failure of either therapist or patient, but as a commonly occurring

need in some psychotherapies, especially with difficult patients. A consultative team sensitive to the nature of the patient-therapist relationship and careful to avoid devaluing the therapist can make a significant contribution to a psychotherapy. (abs.)

127. Bittker, T.E. Role conflicts for psychiatrist-administrators in prepaid psychiatric settings. *Psychiatric Opinion* 15(4): 40-41, 1978.

A series of role conflicts for psychiatrist/administrators in prepaid psychiatric settings (clinician vs. administrator, system consultant vs. case-oriented consultant, father figure vs. bureaucratic administrator, and system-wise consultant vs. mental health advocate) are described. Various conflict-of-interest situations wherein the psychiatrist's loyalties to patient conflict with loyalties to a health care institution are evaluated, and solutions to these role conflicts are proposed. It is recommended that the psychiatrist (1) sensitize himself or herself to the existence of these role conflicts, (2) openly acknowledge these role conflicts, (3) make priorities and loyalties public knowledge, (4) define criteria for success in the roles, (5) consult regularly with others in similar situations, and (6) come to terms with the compassionate exercise of power.

128. Black, M., Harris, J. From 'child guidance' to 'child and family psychiatry': Problems of interdisciplinary communication. *Bulletin of the Royal College of Psychiatrists* (London) July 1978. pp. 132-134.

Problems of interdisciplinary communication among practitioners who provide services to children have resulted in attempts to clarify the role of a psychiatric consultant working in a team. Child psychiatrists have a responsibility to a wide network of families and other professionals and are employed by hierarchies within their catchment areas. The conflict between administrators, who operate within hierarchies, and a partially autonomous service, of which some members are also answerable to hierarchical systems rather than being free agents, is illustrated. A reconstituted group of the joint working party will need to meet regularly to continue the planning of a clinical service in child psychiatry. It is essential that each member of the new group who is part of a hierarchical system be clear about the limits of delegated responsibility. It will also be necessary to build links with the Joint Consultative Committee and to explore alternative concepts to the term "child guidance" that would link together the local agencies working with children and families.

129. Braceland, F.J. Overview of psychiatry: An editor's viewpoint. *Journal of the Tennessee Medical Association* 71(10):729-737, 1978.

Current trends and future prospects for psychiatry within the medical profession are reviewed. Changing social and political values which have eroded the public confidence have significantly affected psychiatry and the mental health service system in general. The medical model is increasingly under fire, and psychiatrists have been accused of undue emphasis on the sociological problems underlying mental illness, thereby creating a cult of irresponsibility and providing criminals and other deviants with an alibi for misconduct. It is argued that future improvements lie in consultative liaison psychiatry, which offers the opportunity to use medical and psychiatric training in treating mental illness and uncovering the biological and psychosocial bases of health and disease. Future psychiatrists will provide a bridge between genetics, biology, and clinical medicine, on one hand, and the behavioral sciences on the other.

130. Brodie, H., and Keith, H. Mental health and primary care. *Psychosomatics* 20(10):658-659, 1979.

Implications for mental health professionals, primary care physicians, and professional educators of the fact that a majority of mental health services are provided by primary care physicians are discussed. It is contended that primary care physicians need adequate training in the psychological aspects of patient care in collaboration with mental health professionals and in the understanding of the interface of physical and mental illness. It is suggested that consultation/liaison psychiatry offers a framework for educating primary care providers and mental health specialists in an interdisciplinary approach. A suggested mental health curriculum for medical students consisting of psychosocial dimensions of health care, human life span development, physical effects of life stresses and lifestyle behaviors, psychiatric side-effects of medical problems, psychopharmacology, the usefulness of various psychotherapies, and basic psychopathology is suggested.

131. Collins, G.B. Psychiatric consultation in alcoholism agencies. *Alcohol Health and Research World* 4(2):45-48, 1979.

Suggestions are made for the use of psychiatric consultation by alcoholism agencies. Reasons for using psychiatric consultation are enumerated. Eight indications that the psychiatrist should be called by the agency are listed. Additional suggestions are made for finding a psychiatrist who fits the agency's needs, for cultivating a positive trusting relationship with the consultant, and for

referring patients early and often. It is concluded that psychiatric fees, although they may initially seem high, buy a great deal of physician time, professional backup, enhanced marketability, liability protection, and staff education. The possibility of patient resistance to such consultation is also noted.

132. Draper, E., and Nitsberg, H. Winking, blinking, and nod: A look at the problem of moonlighting and psychiatric consultation in graduate medical education. *Journal of Psychiatric Education* 2(2):197-209, 1978.

The problem of moonlighting among psychiatric residents is discussed and a pilot program for capitalizing on the situation is described. Results of a national survey indicate that all residency directors in training centers are uncomfortable dealing with clandestine moonlighting, consultation, or private practice among residents. The program incorporates educational and monetary augmentation for residents' service in community agencies and brings the consultation experience by the resident into the regular work week. It also includes a pooling plan to make all consultative incomes equitable for participants.

133. Early diagnosis: "We want to know whether Jimmy is ready to start kindergarten." *Exceptional Parent* 8(1):D14-D18, 1978.

A case history is briefly presented in which the parents of a slowly developing nursery school age child are concerned that their child has a problem which has not been identified and that their pediatrician has withheld information from them. The pediatrician's and the parents' points of view are both presented and then evaluated by a consulting psychiatrist. It is suggested that parents have a responsibility to repeat their questions until they have been heard clearly, understood, and answered adequately and that it is important also for professionals to spell out the reasons for their decisions and actions. It is concluded that the failure of parents and professionals to successfully communicate their concerns may inhibit parents' confidence and growth-promoting actions on their child's behalf and may impose artificial constraints on parents' ongoing, unself-conscious ways of nurturing and teaching their children.

134. Eisenberg, L. Mental health services: Equity, quality, and constraints. *Hospital and Community Psychiatry* 20(12): 781-787, 1978.

In a paper presented at the 30th Institute on Hospital and Community Psychiatry, held September 1978 in Kansas City, Mo., the current restrictions on resources for mental health care are

discussed. Despite public cynicism about the motives of professionals who plead for additional resources for mental health, professionals have a continuing obligation to be advocates for patients and to lobby for universal access to effective services. It is suggested that the best use of resources would subsidize a full range of services for psychotic patients, consultation and collaboration with primary practice physicians to enhance their skill in the management of psychiatric and psychosomatic problems, and comprehensive maternal and child health care programs. The need for funding for services to minority groups, who continue to bear a disproportionate health burden as reflected in longevity and mortality rates, is emphasized. It is also recommended that at least 5 percent of health costs be allocated for research purposes. (abs.)

135. Froese, A.P. Pediatric referrals to psychiatry: III. Is the psychiatrist's opinion heard? *International Journal of Psychiatry in Medicine* 8(3):295-301, 1978.

The influence of a psychiatrist's diagnosis on the final medical discharge diagnosis of 220 children aged 2-18 years was examined. At least one psychiatric diagnosis was made for 205 of 220 children. However, only 78 of 242 psychiatric diagnoses given the 205 patients were reflected correctly in the medical discharge diagnoses. In addition, 7 of 15 patients considered to be normal by the consulting psychiatrist had a psychiatric or mixed medical/psychiatric diagnosis included in the discharge diagnoses. Psychophysiological disorders, psychoses, and special symptom diagnoses were likely to be correctly reflected in the discharge diagnoses, while depression and adjustment reaction were not. Possible reasons why the psychiatrist's diagnostic opinion was not correctly reflected in the discharge diagnosis in over half of the referrals are discussed. It is suggested that pediatricians may be reluctant to label their patients neurotic for life or may consider the problem transient. However, these theories are discounted by the fact that seven patients considered to be emotionally normal when assessed by the psychiatrist were discharged with a psychiatric or mixed medical/psychiatric diagnosis. (abs.)

136. Gans, J.S. The consultee-attended interview: An approach to liaison psychiatry. *General Hospital Psychiatry* 1(1): 24-30, 1979.

The consultee-attended (C-A) interview, a format in which the liaison psychiatrist interviews the patient in the consultee's presence, is described. The background, strategy, concepts and methods, obstacles and resistance, and countertransference difficulties of the C-A interview are discussed. The C-A interview is an experimental teaching instrument with which to facilitate

consultees' "participant-observation," a clinical posture that complements other approaches to the care of sick people.

137. Garrick, T.R.; and Stotland, N.L. How to write a psychiatric consultation. *American Journal of Psychiatry* 139(7): 849-855, 1982.

Presents a conceptual and practical scheme to help potential consultants make decisions about the content, style, and wording of their written communications. Each of the components of the consultation document--headings, openings, history, examination, and formulations-- is considered in terms of its effect on the liaison with the consultee and the care of the patient.

138. Goldstein, L.S. Federal support for consultation-liaison services. In: American Psychiatric Association. *Continuing Medical Education: Syllabus and Proceedings in Summary Form*. Washington, D.C.: the Association 1978. p. 175.

A summary of a paper read at the 131st Annual Meeting of the American Psychiatric Association, held in Atlanta, May 1978, is presented. A grant program developed by the Federal Government to aid in linking community health centers and community mental health centers is discussed. An up-to-date account of the program is given and future plans are outlined. An examination of the relationship of this program to consultation/liaison psychiatry is included. (abs.)

139. Graham, D.T. Presidential address--1979: What place in medicine for psychosomatic medicine? *Psychosomatic Medicine* 41(5):357-367, 1979.

In the Presidential Address to the 1979 meeting of the American Psychosomatic Society, held in Dallas, issues in psychosomatic medicine are examined. A major problem in the field is that problems primarily considered to be emotional/psychological or psychiatric in nature are consigned to it and there has been no fundamental change in the mind/body dichotomizing within the larger field of medicine. This is particularly evident in consultation/liaison psychiatry, where the consultant is generally presented with the problem patient who had baffled or annoyed the physician. Factors contributing to this state of affairs include a lack of conceptual clarity, particularly relating to stress and psychosocial factors. The question of causality, too, is a chronic source of trouble in psychosomatic medicine. It is suggested that the psychosomatic approach is compatible with a standard medical model. Further, existing evidence supports the existence of psychosomatic specificity.

140. Greenblatt, M. Liaison psychiatry in daily medical practice. *Psychosomatics* 19(8):453-454, 1978.

The importance of developing a broad liaison-consultation approach in psychiatry is discussed as well as its application in the hospital ward. Psychiatric skills are needed in all aspects of medicine and lead to decreased hospital stays for patients, increased ambulation, reduced ward personnel turnover and greater staff and patient satisfaction. Also, consultation liaison psychiatry utilizes all the skills--biological, social, and psychological--for which the psychiatrist was trained. In the hospital ward the role of the consultant liaison psychiatrist is to diagnose and treat emotional upset and behavioral aberrations and also understand how the ward environment impinges on the patient's life, illness, and recovery process.

141. Gunther, M.S. The psychopathology of psychiatric consultation: A different view. *Comprehensive Psychiatry* 20(2): 187-198. 1979.

The psychiatric consultation situation, where the need for such consultation arises in the course of routine hospitalization for medical/surgical illness, is analyzed in terms of the assumption that the immediate goal of sound psychiatric consultation is not simply the cure of the patient's problem, but rather is the restoration of the professional competence and confidence of the primary physician and the treatment group so that he or she can reactivate the stalemated treatment situation and thereby once again become therapeutically effective. A model of psychiatric consultation is described and procedures developed for the restoration of the physician's competence to manage the patient's psychiatric problems.

142. Hales, R.E. Dying patients: A challenge to their physicians and consultation psychiatry. *Military Medicine* 145(10): 674-680, 1980.

The dying patient is considered from the perspectives of the patient, the physician, the doctor-patient relationship, and consultation psychiatry, in order to provide understanding and support to the physician and the patient through the process of dying. It is suggested that personal conflicts of physicians concerning death will tend to result in decreased involvement with terminal patients, and that physicians' misconceptions about death will definitely affect their patients' response to terminal illness. Consultation psychiatry may help patients and their physicians to understand and better deal with the psychosocial consequences of dying. Reasons for psychiatric consultations, impact upon patients, and evaluation of such services are considered.

143. Hales, R.E., and Fink, P.J. A modest proposal for consultation/liaison psychiatry in the 1980s. *American Journal of Psychiatry* 139(8):1015-1021, 1982.

Discusses how consultation/liaison psychiatry has promoted closer cooperation between primary care and psychiatry in the general hospital setting and has increased physician concern for psychosocial issues, while at the same time creating financial and organizational problems for consultation/liaison programs. It is argued that all large general hospitals should have consultation/liaison services, and that these services should be funded through third-party reimbursements.

144. Hall, R.C.; Holt, R.E.; and Beresford, T.P. Psychiatric education in the 1980s: The role of consultation psychiatry. *Psychosomatics* 24(8):745-748, 1983.

Contents that the remainder of this decade will see a significant extension in the use of the general hospital as a training site for psychiatrists. The general hospital is a worthy training site since it provides an ideal arena for the integration of psychiatry with other medical specialties. The general hospital provides a setting in which the resident can encounter the multiple variables and performance demands that stimulate the acquisition of knowledge and the development of professional role attributes, qualities essential to the consultation process.

145. Harris, J. Child observation and assessment centres: Psychiatrists' and social workers' difficulties. *British Journal of Psychiatry* (London) 132:195-199, 1978.

Ways are discussed in which the psychiatrist can assist social workers in British child observation and assessment centers filled with older adolescents who stay indefinitely, a situation contrary to the purposes of the centers, which are designed to meet short-term emergencies and crisis needs of young people under 18 years of age, provide assessment, and refer them to more appropriate places. The demand by families and the community for immediate action precludes consultation with other welfare or psychological services. However, if the child is admitted to the center, high-quality coordinated work involving interdisciplinary case conferences, consultation across related health disciplines, and meeting the child in the company of his family becomes possible. Nonetheless, there are increasing numbers of older adolescents for whom longer term provision is unavailable, and who are rapidly filling up the centers. Only within the prison service, the special hospitals, a diminishing number of psychiatric hospitals, and child observation and assessment centers do admissions occur because the community is able to insist on this. The variety of

problems handled at the reception centers in question is illustrated. An interdisciplinary team in which primacy rests with the social workers is advocated.

146. Heinrich, R.L. Behavioral medicine: Approaches and applications. *Psychiatric Clinics of North America* 1(2):323- 334, 1978.

The developing applications and boundaries of behavioral medicine and its relationship to psychosomatic medicine and consultation/liaison psychiatry are surveyed, and a case that illustrates the behavioral approach to chronic pain is presented. Investigators and clinicians in the field of behavioral medicine believe that the tools of behavioral analysis and the technology of behavioral interventions can be successfully applied to clinical medicine; view the physician and other health care providers as powerful, reinforcing agents for the maintenance of health and illness behavior; see the signs and symptoms of medical disorders as behaviors representing adaptations to and interactions with specific psychosocial environments; and are concerned with systematically defining and empirically validating treatment procedures. It is reported, however, that presently the lack of long-term followup, too few subjects treated to establish the generalizability of the findings, and statistical but not clinical significance are problems that undermine the value of the research literature.

147. Hengeveld, M.W., and Schalken, H.F.A. The psychiatrist with the hospital patient: An examination of clinical consulting psychiatry. *Maandblad voor de Geestelijke Volksgezondheid* 34(3):200-220, 1979.

Developments in theory and practice within clinical consultation psychiatry are discussed followed by a related report, based on a study of the literature, involving 100 consultants at the University Hospital in Amsterdam. The study describes what consultation psychiatric work entails, its significance, and results. It is emphasized that consultation psychiatry is an important form of medical, psychiatric, and diagnostic mental health care, which includes psychotherapeutic and system oriented aspects. (abs.)

148. Hirschowitz, R.G. Consultation to changing organizations. *Psychiatric Opinion* 15(12):29-33, 1978.

Psychiatric consultation to changing organizations is discussed. Case vignettes are provided to illustrate problems encountered in consultation. The consultant needs to explore a changing organization with cognitive maps that define the dynamics of change and group psychological responses to it. When the diagnostician

manages the diagnostic process so that management teams participate, diagnosis becomes intervention. In recommending, influencing, or participating in corrective interventions, the consultant's primary emphasis is strategic: specification of objectives, construction of vehicles for their realization, and planning the allocation of time and resources. It is concluded that when the consultant's tasks are intelligently directed and grounded in humanistic, holistic, and Hippocratic values, the psychiatric consultant can endure in an unsteady organizational environment.

149. Hurst, D.M. Some effects of the consultation-referral process on subsequent analytic work. *Journal of the American Psychoanalytic Association* 28(3):605-621, 1980.

Discusses some possible consequences of the usual consultation and referral procedures in psychoanalysis. Using four clinical illustrations, it is suggested that the consultant may play a much more important role in the patient's psychic life than might be expected. The availability to the patient of previous information about the analyst can retard the development of the analytic process and can also prevent an analysis from occurring. Certain circumstances, such as wide disparity between the status of the consultant and the treating analyst, may predispose the patient to develop early fantasies that relate to both of them.

150. Karasu, T.B.; Waltzman, S.A.; Lindenmayer, J.-P.; and Buckley, P.J. The medical care of patients with psychiatric illness. *Hospital and Community Psychiatry* 31(7):463-472, 1980.

Evidence is presented of a high incidence of undiagnosed physical illnesses in psychiatric patients as observed in a survey of inpatient, outpatient, and consultation services. The finding is consistent with that of other researchers and highlights the need for a comprehensive medical examination of all mental patients. The clinical diagnostic interface between physical and psychiatric disorders is examined, along with medical complications of psychiatric treatment and the reaction of psychiatric patients to somatic illness. These maladaptive reactions in thinking and behavior are prevalent in inpatients whose premorbid adjustment may already be tenuous and whose preexisting potential for ego function regression is already high. (abs.)

151. Kimball, C.P. Liaison psychiatry: Of approaches and ways of thinking about behavior. *Psychiatric Clinics of North America* 2(2):201-210, 1979.

Liaison psychiatry is discussed in relation to conceptions of psyche and soma and methods of conceptualizing behavior. Liaison is

derivative from consultation psychiatry and may be viewed as the process through which the interrelationships sought by psychosomatic medicine are identified, formulated, clinically tested, and transmitted to those in other areas of medicine. A comprehensive approach to the understanding of illness, its development, onset, and phases of treatment is central. Beginning with the patient, the focus of liaison psychiatry extends to the milieu in which the patient is treated.

152. Kirstein, L. A health care program for hospital staff. *General Hospital Psychiatry* 1(2):134-138, 1979.

The contractual arrangements, implementation, and evaluation of a health care delivery program for nonprofessional hospital employees are described, and the significance of one aspect of psychiatric consultation to issues of general hospital health care delivery is discussed. Changes in patients' perception of treatment were evaluated by random surveys of representative clinical and ward populations before and after this program was implemented. The program was evaluated by precourse/postcourse questionnaires completed anonymously by the hospital personnel group. The program was found to be successful in generating lists of major health care delivery problems and some possible solutions. The majority of personnel enjoyed and benefited from this program. (abs.)

153. Kleinman, A. Clinical relevance of anthropological and cross-cultural research: Concepts and strategies. *American Journal of Psychiatry* 135 (4):427-431, 1978.

A method through which findings from anthropological and cross-cultural research can be applied to problems affecting patient care is presented. The clinical social science approach emphasizes the distinction between disease and illness and cultural influences on the ways clinical reality is conflictually construed in the ethnomedical models of patients and the biomedical models of practitioners. The relevance of such research extends beyond special clinical concerns arising from ethnic differences to ubiquitous problems which result from cultural influences on all aspects of health care. Consultation/liaison psychiatry is a particularly appropriate vehicle for introducing clinical social science into medical and psychiatric teaching and practice. (abs.)

154. Knight, J.A. The liaison psychiatrist in kidney transplantation. *International Journal of Psychiatry in Medicine* 10(3):221-233, 1980.

The role of consultation/liaison psychiatrist with patients and colleagues in kidney transplantation is considered, as are areas for

exploration in evaluating prospective donors and recipients. While body image problems emerge infrequently in kidney transplantation, careful psychological screening may identify some of these potential difficulties and set the stage for dealing with them. It is suggested that pertinent issues and possible complications with patients require an effective, preventive approach. It is further suggested that the atmosphere on the transplant unit should be constantly monitored in order to nurture a healing environment for both patients and staff. (abs.)

155. Krakowski, A.J. Liaison psychiatry in North America in the 1960s. *Bibliotheca Psychiatrica* 159:4-14, 1979.

A concise review of the status of consultation/liaison psychiatry in North America during the recent decade is presented, centering mainly on its scope, aims, and function. Included are a critical review and interpretations of its participants: the consultee, the consultant, and the patient, with elaboration on the nuances of this triadic relationship and its dynamics as seen in practice. An evaluation of its psychosocial benefits as well as resistances is undertaken. The role of research and the educational goals are recounted. It is concluded that the psychosomatic model will be useful in the development of a professional identity among liaison psychiatrists, and that their chances to serve as a model for other psychiatrists will stem from realistic convictions of the psychosomatic model's soundness and of its usefulness in patient management. (abs.)

156. Krakowski, A.J. Liaison psychiatry in the West: The view from 1977. *Psychotherapy and Psychosomatics* 31(1-4): 98-105, 1979.

The current status of consultation/liaison psychiatry in the West is reviewed. Its aims, functions, and scope in diagnosis and treatment of general hospital patients outside of psychiatric departments are described. A critical appraisal is made with regard to the triadic relationship of its participants. Its benefits vis-a-vis resistances are illuminated in the context of psychosocial process. Its role in research and medical education is recounted and thoughts about its future developments are offered. (abs.)

157. Kreisman, J.J. The psychiatric resident as consultant. *Psychiatric Annals* 8(4):67-76, 1978.

Experiences in two psychiatry training programs are used to illustrate the usefulness of different approaches in the residency education of the consultation psychiatrist. Roles of the consultant discussed include patient-centered consultation and consultee- or situation-oriented consultations. The interaction of psychology

and medicine and dealing with social issues such as child abuse, poverty, prejudice, and violence are also noted as subjects dealt with by the resident psychiatric consultant. It is concluded that the goal of this residency training should be to weld a humanistic biologist capable of contributing to her or his patients, profession, and the world.

158. Krell, H.; Heller, D.; Erskine, K.; and Preis, K. Use of the psychiatrist in cases of child abuse. In: American Psychiatric Association. Continuing medical education: Syllabus and proceedings in summary form. Washington, D.C.: the Association, 1978. pp. 202-203.

A summary of a paper read at the 131st Annual Meeting of the American Psychiatric Association, held in Atlanta, May 1978, is presented. The potential roles of the psychiatrist in consulting, education, and provision of direct service in cases of child abuse are reviewed. The consulting duties may include communication, emergency intervention, evaluation, support for team members who are working with the family, and coordination of the team approach. The educational duty may be primarily to work with the team members to deal with the strong feelings that may be aroused by close contact with the frequently appalling situation in which they are working. A specific psychiatric diagnosis may also require the psychiatrist to provide direct care to the subject family. The role of the psychiatrist in providing expert testimony in case of court involvement is also noted. (abs.)

159. Krupp, N.E., and Rynearson, E.K. Consultation-liaison: A patient-based overview. *Psychosomatics* 20(2):108-117, 1979.

An overview of consecutive psychiatric consultations in a busy general hospital is presented. Based upon case history examination, the components of an effective consultation/liaison service are identified. The ideal consultation/liaison psychiatrist tries to combine competent psychiatric eclecticism, a reasonably strong and current medical background, and a good knowledge of the responses of normal patients to medical stress. He or she should seek the realistic, achievable goals of the pure liaison counterpart by being available for routine consults, followup, and communication with staff at predictable times.

160. Lamb, H.R., and Peterson, C.L. The new community consultation. *Hospital and Community Psychiatry* 34(1): 59-64, 1983.

A large proportion of chronically mentally ill persons live in nonmedical community residential facilities run by administrators

and staff who are not specifically trained in the management of psychiatric patients; this makes consultation to residential facilities an issue of high priority. Consultants should be familiar with the facility's operating procedures, the range of social and vocational potential among long-term patients, and the needs of some patients for highly structured programs. They should be aware of the administrator's attitudes toward mental health professionals and be prepared to deal with problems that can arise when they attempt to provide both consultation and direct service to the same facility. The authors recommend that consultants advise administrators on issues such as determining admission criteria, understanding the mental health system, and handling a variety of difficult behaviors.

161. Leigh, H., and Reiser, M.F. A systematic approach to psychiatric consultation. *Journal of Psychosomatic Research* 26(1):73-76, 1982.

Discusses a method for gathering and organizing data about patients that takes into account the biological, psychological (personal), and environmental dimensions of the patient. The three dimensions are considered in terms of three time contexts: current, recent, and background. This 3-by-3 format provides the Patient Evaluation Grid which may be used to summarize comprehensive data in psychosomatic medicine and psychiatric consultation.

162. Levitan, J.S., and Kornfeld, D.S. Clinical and cost benefits of liaison psychiatry. *American Journal of Psychiatry* 138(6):790-793, 1981.

A liaison psychiatrist participated in the postoperative care of a group of elderly patients who underwent surgery for fractured femurs. Clinical outcomes for this group were compared with a control group of patients who were not treated by a liaison psychiatrist. Length of stay for the treatment group was 12 days shorter than for the control group, and twice as many patients in the treatment group returned home rather than being discharged to a nursing home or other health-related institution; therefore, a substantial reduction in the cost of their medical care was effected. The authors suggest that psychiatric liaison services should be viewed as a potential cost containment mechanism for general medical care.

163. Levy, A.M. The resolution of child custody cases--the courtroom or the consultation room. *Journal of Psychiatry and Law* 6(4):499-517, 1978.

The viewpoint that the opportunity for solving problems of child custody determination is more favorable in the psychiatrist's consultation room than in the courtroom is presented. A consultation room approach to the reeducation or resolution of the human problems involved in child custody follows a therapeutic model in which open and frank discussion occurs among all parties. Information obtained through psychological tests, clinical interviews, and other means is fed back into the consultation process in order to further clarify and define the existing problems. It is suggested that a willing psychiatrist may find the court and attorneys very cooperative in assisting the consultation room process. (abs.)

164. Lipowski, Z.J. Consultation/liaison psychiatry: Past failures and new opportunities. *General Hospital Psychiatry* 1(1):3-10, 1979.

Although the concept of liaison psychiatry is not new, progress in its development has been slow. Obstacles to its development are examined and new prospects discussed in light of combined economic, political, and social forces which provide the opportunity for an expanded scope of clinical, teaching, and research activities.

165. Lipowski, Z.J. Current trends in consultation/liaison psychiatry. *Canadian Journal of Psychiatry* 28(5):329-338, 1983.

Consultation/liaison psychiatry has grown rapidly and become a subspecialty of psychiatry in the past decade. The author reviews the history of this field at the interface of psychiatry and medicine, offers its definition, and discusses current trends pertaining to the organization of liaison services and to the teaching and research activities of liaison psychiatrists. It is concluded that a liaison service has become a recognized division of a general hospital psychiatric unit for the provision of psychiatric consultation and teaching to the nonpsychiatric departments of the hospital. (abs.)

166. Lipowski, Z.J. Discussion: Liaison psychiatry and the quest for new knowledge. *General Hospital Psychiatry* 5(2):111-114, 1983.

Discusses liaison psychiatry, which has become a subspecialty of psychiatry. A new trend for liaison psychiatrists is to become

involved in collaborative research at the interface of medicine and psychiatry, and this research can be organized with the help of consultation/liaison clinical work. It is concluded that liaison psychiatry's future will depend on the provision of competent clinical service and high quality research.

167. Lipowski, Z.J. Liaison psychiatry, liaison nursing, and behavioral medicine. *Comprehensive Psychiatry* 22(6): 554-561, 1981.

The author proposes several measures aimed at ensuring liaison psychiatry's continued growth. Liaison psychiatry is clearly defined and then discussed in terms of its three main interrelated functions: clinical service, education, and investigation.

168. Lipowski, Z.J. New prospects for liaison psychiatry. *Psychosomatics* 22(9):806-809, 1981.

The author presents a brief history of the emergence and growth of consultation/liaison psychiatry. Several concrete measures aimed at securing liaison psychiatry a place in the health care system in the future are presented. Three key aspects of consultation/liaison psychiatry are discussed separately: organization, education, and investigation.

169. Lipsitt, D.R. Primary care: Action at the biopsychosocial interface. *General Hospital Psychiatry* 2(1):1-2, 1980.

The need for liaison between psychiatry and primary care medicine is discussed. It is noted that the incidence of psychosocial factors in disease range from 25 to 80 percent. However, the importance of psychosocial aspects is not sufficiently stressed in graduate medical education. Thus, primary care practitioners fail to meet the primary care health needs of the nation. Psychiatry, particularly that branch known as consultation/liaison psychiatry, can help redress this educational gap. Such liaison can bring the internist and the psychiatrist together in their understanding of primary care.

170. Lloyd, G.G. Liaison psychiatry from a British perspective. *General Hospital Psychiatry* 2(1):46-51, 1980.

Some differences in the organization of liaison psychiatry between the United States and the United Kingdom are discussed. The fact that much psychiatric morbidity in general hospital patients is unrecognized justifies an expansion of liaison services particularly where referral rates are currently low, as they are in British hospitals. However, it is important that there should be an evaluation of these services together with an assessment of the

complementary role of the liaison nurse. It is also suggested that liaison psychiatrists could make a greater contribution to medical student teaching than they do presently.

171. Lloyd, G.G. Whence and whither 'liaison' psychiatry? *Psychological Medicine* 10(1):11-14, 1980.

The status of liaison psychiatry as a subspecialty is considered. Liaison psychiatry is the interface between psychiatry and other medical specialties through consultation, collaboration, and prevention activities. Liaison psychiatry has generated much recent interest in the United States which is evident in increased funding, fellowships, and resident training programs in this field. In England, liaison psychiatry has received less recognition. While there is abundant evidence of the frequent coexistence of physical and psychiatric morbidity, a repetition of the exaggerated claims of the psychosomatic enthusiasts of the 1940's is to be avoided; psychiatry in general medicine will probably be most effective if it limits its role to detecting and treating patients with demonstrable psychiatric disorders and to increasing staff awareness of these problems, particularly in intensive care, oncology, and rehabilitation units. Liaison psychiatry needs no apologists; its existence is justified by the poor mental health of the physically ill and by the fact that the needs of such patients are not at present being met.

172. Loewenstein, R.J., and Sharfstein, S.S. Psychiatric consultations at the NIH. *General Hospital Psychiatry* 5(2):83-87, 1983.

Reviews the history of the consultation/liaison psychiatry movement in America and describes the consultation/liaison program in a research hospital setting at the National Institutes of Health.

173. Lovitt, R. Psychological testing and consultation/liaison psychiatry. *General Hospital Psychiatry* 4(3):233-240, 1982.

Although the use of psychological testing in medical settings has been limited primarily to psychiatric units, it can add appreciably to teaching and diagnostic efforts on a psychiatric consultation/liaison service. A number of methodological and procedural modifications are necessary to incorporate testing into the diagnostic workup. The psychologists' efforts must be viewed as supportive, and must be geared to take into account the unique problems on medical and surgical units. Testing efforts can be most helpful in identifying (a) patients whose response set or attitude predisposes them toward exaggerating or minimizing emotional difficulties, (b) individuals with conversion reactions or major psychogenic

components complicating their medical disorder, and (c) patients in whom an organic brain syndrome complicates medical adjustment. The MMPI and the Wechsler Adult Intelligence Scale are examples of two objective assessment instruments that can aid in dealing with an array of diagnostic problems. A series of test profiles is discussed with specific comments directed toward demonstrating the utility of psychological tests.

174. Lovitt, R., and Weiner, M. Conservation withdrawal vs. depression in medically ill patients: Rorschach case study. *Journal of Personality Assessment* 44(5):460-464, 1980.

A case study is presented illustrating the Rorschach test findings of a black male patient who appeared depressed upon initial clinical examination, but who illustrated conversion withdrawal, an adaptive nonpathological stress reaction. In this case, clinical differentiation was ambiguous; Rorschach personality assessment provided data valuable in the formulation of a precise differential diagnosis. The Rorschach protocol presented a record of a person responsive to but readily disorganized by the emotional impact of his environment. In order to cope with the severe emotional stresses, he adopted the defenses of withdrawal and inhibition of responsiveness. Psychiatric consultation enabled the medical staff to adopt appropriate management strategies. (abs.)

175. Mackenzie, T.B., and Popkin, M.K. Psychological manifestations of nonbacterial thrombotic endocarditis. *American Journal of Psychiatry* 137(8):972-973, 1980.

Two case reports are presented of patients who had an organic mental disorder that was an early feature of nonbacterial thrombotic endocarditis. Psychiatric consultation was sought in both cases because the patients were thought to be experiencing psychological symptoms reactive to malignancies; however, both were suffering from organic mental disorder. The difficulty of determining at present whether specific psychopathology is characteristic of nonbacterial thrombotic endocarditis is discussed. Factors, in the presence of a progressive or apoplectiform onset of an organic mental disorder, which should cause the psychiatrist to suspect nonbacterial thrombotic endocarditis are noted.

176. MacRitchie, K.J. Life without eating or drinking: Total parenteral nutrition outside hospital. *Canadian Psychiatric Association Journal (Ottawa)* 23(6):373-379, 1978.

Total parenteral nutrition after removal of all or part of the small intestine is reviewed, with particular emphasis in biological and

psychological side effects. It is noted that those who have suffered a chronic debilitating small bowel disease and have previously undergone multiple resections with poor residual nutritional intake, adapt more readily to the regimen than those who suffered from the combined physical and psychological trauma of sudden massive loss of bowel. Assessment of both personality structure and domestic environmental support is advised in cases of elective use of this medical technique. It is concluded that psychiatrists should be consulted when total parenteral nutrition is being considered and utilized to manage any psychological disturbance, frequently observed as depression, following surgery or later.

177. Mai, F.M. Liaison psychiatry: A bridge between many disciplines of medicine. *Psychiatric Journal of the University of Ottawa* 5(4):264-267, 1980.

Despite the movement of psychiatry into the general hospital, a functional separation between psychiatry and medicine and between the psychosocial and the biological orientation persists. Liaison psychiatry has developed to counteract this separation. In order to meet clinical, educational, and research objectives, liaison psychiatrists need expertise in biological, social, and psychological medicine. They can thereby maximize their influence as a bridge between disciplines.

178. Marano, H. The new psychiatry: Getting in step with scientific medicine. *Medical World News* 21(2):45-59, 1980.

Recent developments in psychiatric research and clinical practice are reviewed in support of the view that the specialty is fast becoming a diagnosis-oriented and a data-oriented discipline with laboratory-tested therapy. Increased psychiatric consultation/liaison in medical centers, publication of the DSM-III, and close contacts with other physicians have led to more positive attitudes, as have developments in neuroscientific and psychopharmacological research by the Federal Government and the private sector. NIMH is also investing large amounts in psychotherapy and behavioral intervention programs, as well as in pharmacotherapy. Particular success has been obtained in research with MAO inhibitors and in moves to reclassify previously resistant psychiatric conditions as mood disorders which respond to psychotropic drugs.

179. Marcenaro, M.; Rasore, E.; and Risso, A.M. Psychiatric consultation in an internal medicine department: Considerations and experiences. *Medicina Psicosomatica* 24(2): 169-177, 1979.

Psychiatric consultation in an internal medicine setting was studied. The sample consisted of 77 medical interns, 37 women and 40 men, who were assisted by a psychiatrist in their contacts with patients. Analysis of data indicates that the development of one-sided relationships among physician, psychiatric consultant, and patient was very common. These relationships only tended to highlight the operator's role and identity, rather than the understanding of the patient as a person. It is concluded that in such a situation of the psyche-soma split seems connected with the vocational problem of physicianship and with physician's and psychiatrist's training. (abs.)

180. Maruta, T. Consultation psychiatry: Communication with nonpsychiatric staff. *Psychosomatics* 20(6):418-419, 1979.

Psychiatrists work with medical and surgical colleagues and with paramedical employees who do not share a similar psychiatric background. Therefore, the need for good professional communication with paramedical staff as well as with colleagues is paramount. The case presented in this paper underscores the importance of such communication with all professional staff members who attend the patient and the danger of assuming their understanding of basic psychiatric knowledge.

181. McCartney, J.R. Refusal of treatment: Suicide or competent choice. *General Hospital Psychiatry* 1(4):338-343, 1979.

Issues related to psychiatric consultation involving patients' refusal of treatment are examined within the context of the effects of stress on illness and treatment and implications for informed consent. Patients who have been chronically ill or consider themselves terminally ill are the most apt to refuse medical treatment. Accordingly, liaison psychiatrists may be asked whether refusal of treatment is an act of suicide or a competent choice. In the absence of overt psychosis or delirium this is difficult to assess. It is suggested that the dynamics and affective tones of the patient's reactions to the health care system, as well as to family and friends, are of major significance in such a determination. The actual process of exploring these areas with patients making this choice is often therapeutic in restoring the patient's sense of control or authenticity. Often this process enables them to continue treatment and avoid the impulsive interpersonal anger

that characterizes the suicidal act. Three case studies are presented to illustrate the process of choosing to refuse treatment. (abs.)

182. McCollum, A. T.; Margolin, C.B.; and Lieb, J. Consultation on psychoactive medication. *Health and Social Work* 3(4):71-98, 1978.

The social work clinician's role in prescribing psychoactive medication is discussed. Clinical social workers should be aware of the classes of medication available and of the disorders for which medication may be appropriate. It is suggested that clinicians learn to recognize instances in which they should consider consulting a psychiatrist or other medical professional. The importance of thoroughly preparing the patient for medication is also emphasized. A period of psychotherapy may be necessary before the patient is willing to accept psychoactive drug treatment. It is recommended that the clinician be aware of the complex meanings that the acceptance of medication may have for the patient and develop skill in collaborating with an associate to ensure beneficial and comprehensive treatment. (abs.)

183. McCue, J.D. Psychiatric consultation to internal medicine: An internist's thoughts. *Psychosomatics* 23(8):832-839, 1982.

Discusses problems faced by a general internist in consultation/liaison psychiatry. The psychiatrist may not be familiar with the expectations the internist has of consultations in general or the generally accepted "rules" of medical and surgical consultations. The referring physician's expectations and complaints about psychiatric consultations are also discussed. The range of involvement asked of psychiatric consultants requires them to do some detective work to decide just how much is expected of them.

184. McEvoy, J.P. Psychiatric consultations. *Southern Medical Journal* 71(1):1321-1322, 1978.

The benefits of psychiatric consultation are discussed. Too many modern physicians have the prejudice that each real complaint must reflect some physiologic or structural abnormality. Complaints that do not comply with anatomy or pathophysiology, unusual rendering of complaints, or complaints that the patient cannot clearly describe all should alert the physician to the possibility of psychiatric illness. Several errors in management commonly encountered by the consulting psychiatrist are illustrated, and the relationship of the patient and the consulting psychiatrist in the hospital setting is described.

185. McNair, F.L. At-home rehabilitation of pediatric cancer patients: A team approach. *Health and Social Work* 5(2):50-55, 1980.

Four stages in a family's adjustment to pediatric cancer are identified, and the role of the team's social worker in providing service to these clients is discussed. The four stages in a family's adjustment to pediatric cancer are identified as initial crisis, adjustment, second crisis, and dying and death. The program of the at-home rehabilitation team, a multidisciplinary team which works with pediatric cancer patients and their families in their homes to assist with the child's rehabilitation, is described in relation to the four identified stages. The social worker for the at-home rehabilitation team has three basic roles: program developer, treatment coordinator, and counselor. The other members of the team consist of a project director, additional social workers, two public health nurses, a physical therapist, an occupational therapist, a vocational/educational counselor, a child life worker, a health educator, and a consulting psychiatrist.

186. Miles, J.E. A psychiatric outreach project to a rural community. *Hospital and Community Psychiatry* 31(12): 822-825, 1980.

An outreach program to rural areas lacking sufficient local psychiatric services, which was begun in late 1976 by the University of British Columbia working with the provincial health ministry, is described. Four teaching hospitals in the province were linked with selected underserved communities to provide both direct service and professional and public education. The psychiatry department of Shaughnessy Hospital in Vancouver was linked with the Dawson Creek community, which had good general health facilities but few specialized services for psychiatric patients. Two psychiatrists began monthly 3-day site visits for consultation and education. The staff also provided 24-hour telephone consultation, refresher courses in Vancouver, support for a new psychiatric daycare program in the Dawson Creek general hospital, and funding for a temporary psychiatric nurse for the general hospital. Questionnaires completed by local health professionals indicated the project was a success, and it was of practical value to the professional practice of local physicians, nurses, and social service workers. (abs.)

187. Mimoto, K.; Nishiura, K.; Tominaga, K.; Matsushima, M.; Kono, R.; Kato, Y.; Ogata, R.; and Hikita, K. Psychiatric consultations at medical and surgical wards: The role of

psychiatric consultant. *Folia Psychiatrica et Neurologica Japonica* 36(1):17-22, 1982.

A 1-year survey was conducted on the psychiatric consultation work at Kyushu University Hospital. It was found that an organic brain syndrome was the most frequent psychiatric diagnosis of the referred patients. The most frequent purpose of request for psychiatric consultations was for the management of the patient. The main consultant functions were diagnoses and to advise on the management of the patient. The consultant functions agreed with the purposes of request in many cases, but discrepancies between the two were found about the patient disposition. The nature of the consultant role was compared with some American studies. It was deemed necessary that consultation/liaison psychiatry based on Japan's present conditions, medical and social, should be developed.

188. Mohl, P.C. The liaison psychiatrist: Social role and status. *Psychosomatics* 20(1):19-23, 1979.

Differences between liaison and consultation psychiatry are discussed. It is suggested that to carry out liaison functions effectively, it is important to understand role and status differences between liaison and consultation psychiatrists, especially in those situations where one person is functioning in both roles. It is contended that to carry out systematic liaison intervention, a psychiatrist must become a fully accepted high status member of the ward culture. It is suggested that a knowledge of those situations and patients that a psychiatrist can handle quickly and easily is necessary among hospital physicians and surgeons. It is urged that the liaison psychiatrist regularly attend work rounds and carefully observe nonverbal behavior, noting instances that suggest an unidentified problem area. Five clinical vignettes are presented which illustrate this process of social role change, as the psychiatrist moves through the spectrum from consultation to liaison. It is concluded that once a ward group accepts a changed role, it is much easier to establish systematic systems-oriented case identification, and primary prevention intervention.

189. Mohl, P.C. What model of liaison psychiatry meets whose needs? *General Hospital Psychiatry* 5(3):213-215, 1983.

Discusses the implications of three recently proposed models of liaison psychiatry presented at the annual meeting of the American Psychiatric Association in Toronto, in May 1982: S.A. Cohen-Cole, T.L. Thompson et al., and B. Goodman and M. Swartz proposed educational, screening, and service delivery models, respectively. Additional issues related to the proper central focus of liaison psychiatry are considered.

190. Moore, G.L. Liaison psychiatry: A historical perspective. *Psychosomatics* 20(5):302-303, 1979.

A historical perspective of liaison psychiatry is offered. The development of scientific medicine is traced from the 17th century, when Descartes produced a dichotomous separation of mind and body, through the early 20th century, when the Rockefeller Foundation in 1935 underwrote the establishment of five psychiatric liaison departments at university hospitals. Consultation/liaison psychiatry has developed over recent years in a continuation of the trend of rejoining the psychiatrist and his patient to the rest of medicine. A consensus has been formed that psychiatry is on firm ground when it functions as a medical subspecialty which uses the scientific method to confirm its observations, yet always conforming to the physician's stance of being the patient's advocate. It is suggested that the general hospital psychiatrist is able to synthesize medical and psychosocial data for integration of patient care.

191. Moore, G.L. The adult psychiatrist in medical environment. *American Journal of Psychiatry* 135(4):413-419, 1978.

The position of the adult psychiatrist in the medical environment is discussed with special attention to prerequisite training and problems which are encountered uniquely in this environment. It is argued that psychiatric residency training should foster attitudes conducive to continuing interest in the problems of organic medicine in general and problems relating to human behavior specifically. The psychiatrist should supplement psychiatric education with a medical reading program, attend general medical conferences, and be part of the medical community. Suggestions for successful consultative psychiatry are presented. Special problems are examined which include evaluation of somatic complaints, dealing with suicidal and homicidal patients, the management of substance abuse, and liaison psychiatry.

192. Moss, E., and Davidson, S. The development of a psychiatric rehabilitation service: Two-year pilot project. *International Journal of Rehabilitation Research* 3(1):45-55, 1980.

A 2-year pilot project is described which was designed to introduce a centralized rehabilitation service within the Shalvata Psychiatric Center, a medium-sized psychiatric hospital in Hod Hasharon, Israel. The service is based on a rehabilitation/activity therapy model, in which the hospital is conceptualized as a setting in which patients may develop or recover social and vocational skills needed to function adequately in the community. It has

drawn on existing, motivated staff from all mental health professions represented at the hospital and works closely with all in-hospital wards and the day hospital. Six areas with which the rehabilitation service has attempted to deal are discussed: activity therapy/rehabilitation groups; the vocational guidance unit, the aftercare therapeutic social club, in-hospital rehabilitation consultation, liaison activities with community-based facilities, and job placement. (abs.)

193. Nadelson, T. Psychiatric consultation in the hospital. *Psychiatric Annals* 8(4):54-60, 1978.

The role of the psychiatric consultant in the hospital, with particular reference to dealing with the patient's physician, is discussed. Two case histories are presented in which the psychiatric consultation leads to an understanding of the feelings of the physician in dealing with the patient, and the way these feelings may interfere with the effective treatment. It is noted that understanding the structure within the hospital is essential to effective consultation. It is concluded that the psychiatric consultant can be important in nurturing the most appropriate biopsychosocial perspective in the staff at the hospital.

194. Neill, J.R. Once more into the breach: Doubts about liaison psychiatry. *General Hospital Psychiatry* 5(3): 205-208, 1983.

The author, a consultation/liaison psychiatrist, reviews five unanswered questions about liaison work. It is argued that those who promise more than can be delivered in the name of "holistic" and "biopsychosocial" medicine may lead liaison psychiatry astray.

195. Nocks, J.J. Alcoholism consultation/liaison: An effective way to reach alcoholics and teach professionals. *American Journal of Drug and Alcohol Abuse* 8(3):389-398, 1981.

Alcoholism is a very common disease in general hospital patients. Yet negative attitudes toward alcoholism and the need for education among professionals often lead to underdiagnosis and inadequate referral. The author describes how consultation with liaison can be effective in reaching more alcoholic patients and teaching professionals. He points out that while this has commonly been accepted in general psychiatry, the liaison approach seems to have rarely been utilized to its fullest potential in the alcoholism field. One alcoholism consultation/ liaison service is presented in detail; encouraging findings and future directions are discussed.

196. Offer, P.A. Development of psychiatric nursing outpatient clinic. Professional action through positive thinking: A case in point. *American Journal of Nursing* 80(8):1454-1455, 1980.

Following a political struggle involving philosophy and finances, and the withdrawal of a university psychiatry department from an outpatient psychiatric clinic, the unit was reorganized and kept running as a psychiatric nursing outpatient clinic. The university hospital administration was persuaded by four psychiatric nurses that the clinic was important to the community and to the university as a training facility for psychiatric nurses and that the clinic could function without the psychiatry department. A part-time psychiatrist was hired for medical consultation and to share administrative responsibilities with the clinical nurse specialist. The professional and assertive actions of the psychiatric nurses are described as resulting in the retention of a valuable community service.

197. Oxman, T.E., and Smith, R. Consultation/liaison psychiatry within a family practice. *Social Psychiatry* 17(2):101-107, 1982.

Family medicine is based on a holistic approach to medicine that overlaps psychiatry. Psychosomatic medicine represents the common ground between the two disciplines and is typified by consultation/liaison psychiatry. With the predicted shortage of psychiatrists and the high prevalence of mental disorders, the relationship between psychiatry and family medicine is becoming increasingly important. This paper reviews the definition and principles of family medicine and consultation/liaison psychiatry and describes an example of a mutually beneficial relationship at the University of Cincinnati.

198. Pardes, H. Future needs for psychiatrists and other mental health personnel. *Archives of General Psychiatry* 36(13): 1401-1408, 1979.

Future needs for psychiatrists and other mental health personnel are discussed. Approximately 15 percent of the population suffers a diagnosable mental disorder, and with the increasing availability of community-based mental health services, growing demand is placed on the mental health specialty sector. Though the general health sector and nonmedical mental health specialists provide services to a large proportion of this case load, psychiatrists possess unique skills for the diagnosis and treatment of mental disorder and for the provision of consultation and liaison services to nonpsychiatric physicians. In spite of the need, a number of factors, including restrictions on foreign medical graduates and

Federal emphasis on the primary care specialties, has created an accelerating reduction in the production of psychiatrists. The Federal Government and medical schools are encouraged to devise strategies collaboratively to address issues to ensure an adequate supply of psychiatrists for the future. (abs.)

199. Pardes, H., and Pincus, H.A. Treatment in the seventies: A decade of refinement. *Hospital and Community Psychiatry* 31(8):535-542, 1980.

Treatment of mental disorders during the decade of the 1970's is reviewed and characterized as a decade of increasing refinement and specificity of existing treatments. There was increasing focus on the negative effects of various treatments, such as deinstitutionalization, and a stronger scientific basis for some treatments emerged. For instance, the field of somatic treatments saw a greater and more sophisticated use of lithium, accompanied by concern about possible side effects of goiter and renal changes; greater specificity of the antidepressants; more widespread monitoring of plasma levels; and growing attention to the tardive dyskinesias. In psychotherapy there was a change toward more eclectic and pragmatic approaches, as evidenced by the combining of behavioral and dynamic techniques and an increased use of short-term psychotherapies, plus a concern with efficacy. Ties between the mental health care and general health care fields became stronger, as evidenced by the growth of consultation/liaison programs, the often combined delivery of mental and physical health services, and advances in behavioral medicine. The continuation of such trends, greater rigor in diagnostic systems, and increased focus on prevention are predicted for the 1980's. (abs.)

200. Parkes, C. On the use of psychiatric resources for indirect service. *Bulletin of the Royal College of Psychiatrists* (London). Feb. 1978. pp. 29-33.

Recommendations for the use of psychiatric resources for indirect service, suggested by a multidisciplinary task force of the Royal College of Psychiatrists in England, is presented. The group was formed to consider the extent to which psychiatric resources should be devoted to collaboration and consultation with other care givers rather than to the provision of direct clinical service, and to look at the implications for the planning of services and training of psychiatrists. Topics discussed include the Community Psychiatric Service, the Primary Care Team, volunteers and counseling services, educational services, consultation in other institutional settings, and logistic and organizational issues. Suggestions are made for closing the communication gap between the psychiatrist and care givers. (abs.)

201. Pasnau, R.O. Consultation/liaison psychiatry at the cross-roads: In search of a definition for the 1980s. *Hospital and Community Psychiatry* 33(2):989-995, 1982.

Consultation/liaison psychiatry did not emerge as a prominent psychiatric subspecialty until the remedicalization of the psychiatric profession in the 1970's. The author traces the history of consultation/liaison and discusses the various definitions of the subspecialty. He outlines how consultation/liaison psychiatrists work in general hospitals and medical school departments of psychiatry. The future of consultation/liaison psychiatry, the author says, depends on developments in four areas: psychosomatic research, behavioral medicine, holistic health care, and general hospital psychiatry. To ensure a bright future for the subspecialty, consultation/liaison psychiatrists must meet fiscal, research, and political challenges, make peace with other behavioral scientists, develop close relations with the nursing profession, enjoy the support of medical school departments of psychiatry, and transform the consultation model into a comprehensive consultation/liaison model.

202. Pasnau, R.O., and Gitlin, M.J. Psychological reactions to sterilization procedures. *Psychosomatics* 21(1):10-14, 1980.

The complex psychiatric problems relating to the voluntary or involuntary termination of fertility are discussed. Six case studies are provided to illustrate some of the varied problems encountered in consultation/liaison work with people who have experienced termination of fertility. Psychological problems include normal grief, relief, severe distress, depression, and delayed neurotic reactions. The role of the liaison psychiatrist is two-fold: to educate the medical team and raise awareness of termination psychiatric problems and to sensitize the medical team to the patient's emotional needs.

203. Perl, M., and Shelp, E.E. Psychiatric consultation masking moral dilemmas in medicine. *New England Journal of Medicine* 307(10):618-620, 1982.

At times psychiatrists are consulted when their fellow physicians face moral dilemmas related to patient care. In this article, the authors discuss their view that such moral issues may be masked as requests for help for a "depressed patient" or a "management problem."

204. Perry, S., and Viederman, M. Adaptation of residents to consultation/liaison psychiatry. Working with the physically ill. *General Hospital Psychiatry* 31(2):141-147, 1981.

When working with hospitalized physically ill patients, psychiatry residents may impose a pseudoanalytic, rigidly biological, or overly sympathetic approach. These approaches often fail to address the special requirements and altered psychological state of the physically ill. To have a therapeutic impact on such patients, the psychiatrist needs to assume an engaging, more spontaneous "therapeutic stance" and deviate from anonymity, abstinence, and neutrality. In learning how these deviations are dictated by the therapeutic intent by the patient's character style and psychodynamics, the resident acquires a model of influence useful in other areas of psychiatry.

205. Raphael, B. A primary prevention action programme: Psychiatric involvement following a major rail disaster. *Omega* 10(3):211-226, 1980.

A primary prevention program implemented immediately following a major rail disaster in Granville, Australia, is described. Because of the high mortality, services were oriented toward the provision of preventive counseling for bereaved families as well as support for the injured. Emergency counseling services were provided at the city morgue. Subsequently, coordinating, consultative, and educational programs were instituted in the affected health region. Counseling bereaved families was continued through appropriate specialized community services. High-risk groups of bereaved were delineated and special emphasis was given to individual care of these persons. Recommendations are made concerning the relevance of such a program to the personal disasters of life. (abs.)

206. Rich, C.L. Consultation psychiatry in a rural private practice. *Psychosomatics* 21(7):567-580, 1980.

The author reviews the psychiatric consultations of 50 patients admitted to 2 rural community hospitals to see how such service differs from that of university medical school hospitals. The appropriateness of referrals is attributed to the education the author provided to the hospital staff, which emphasized differential diagnosis.

207. Sandor, R.S. Hypnosis as an "entree" for consultation/liaison psychiatry. *General Hospital Psychiatry* 2(1): 65-68, 1980.

In addition to its indicated uses, hypnosis can play another important, more indirect role in consultation/liaison psychiatry. It can serve the consulting psychiatrist as an entree to physicians or those who have rejected traditional psychiatric help. Four case studies which illustrate this point are presented and discussed.

208. Schubert, D.S.P. How the liaison psychiatrist can improve his usefulness. *Psychiatric Annals* 9(12):36-38, 1979.

Suggestions are made for increasing psychosocial sensitivity of nonpsychiatrists by the consultation/liaison psychiatrists. Acceptance of referrals on difficult patients is recommended. The liaison psychiatrist should increase face-to-face meeting with potential consultees, show nonpsychiatric physicians ongoing working formulations, and enlist cooperation of leaders in other specialties. Consultation/liaison psychiatry is recommended for teaching medical students. Nonpsychiatric physicians should be encouraged to request explanations at all stages of evaluation and management in order to increase patient compliance with therapeutic regimen. Each suggestion is discussed in detail.

209. Schubert, D.S.P.; Gabinet, L.; Friedson, W.; Miller, S.; and Billowitz, A. The identification of psychiatric morbidity by internists and subsequent selection for psychiatric referral. *International Journal of Psychiatry in Medicine* 9(3-4):317-327, 1978-1979.

A psychosocial information scale used to rate charts of 17 inpatients who later received a psychiatric consultation and 17 who did not during the index admission to examine the identification of psychiatric morbidity on admissions to medical wards. More psychosocial items were generally present in the charts of those patients receiving later psychiatric consultation overall and specifically in the areas of psychiatric chief complaint, history of behavior change, and past psychiatric history. It is concluded that many patients with psychiatric morbidity on medical wards were not so identified and this was a prime reason for their nonreferral, although several of the subgroups of such patients could benefit from psychiatric treatment. Nonpsychiatrists are urged to adopt a more holistic approach to medicine with emphasis on continuity of care to ensure comprehensive diagnosis and management. (abs.)

210. Schubert, D.S. Primary physicians' care and referral of patients with psychiatric problems. *Journal of the National Medical Association* 75(1):13-14, 1983.

Discusses reasons for psychiatric consultations, the timing of referrals, primary physicians' care of depressed and anxious patients, how to deal with patients who refuse a psychiatric referral or consultation, and the nonpsychiatrist physician/ psychiatrist relationship.

211. Schubert, D.S. Psychiatric consultation to internal medicine: A psychiatrist's thoughts. *Psychosomatics* 23(8): 833, 839-843, 1982.

Discusses the psychiatrist's role in consultation/liaison psychiatry. The psychiatrist should accept consultations on all patients referred and not seem hesitant or critical of the physician making the referral. Although communication must flow in both directions, physicians requesting psychiatric consultation are responsible for asking the specific questions they want answered. It is concluded that collaborative communication is necessary between the internist and the psychiatrist in order to achieve the best care as well as the best understanding of the patient.

212. Schwab, J.J. The psychiatrist consultation: Part I. *Journal of Continuing Education in Psychiatry* 40(2): 17-27, 1979.

The role of the psychiatric consultant is discussed, and the theoretical basis for psychiatric consultation is reviewed. Consultation procedures are identified, indicating the importance of patients' reactions. A case history is provided to illustrate formal consultation practices, and a step-by-step outline is developed to aid the psychiatric consultant. It is stated that the consultant's essential obligations are to provide the psychiatric skills and knowledge that benefit general medical and surgical patients and to educate referring physicians and other hospital personnel. Special problems relating to anxiety and depression which the surgical patient faces are discussed.

213. Schwab, J.J., and Kuhn, C.C. Psychiatric consultation. Part II. Potential for therapy. *Journal of Continuing Education in Psychiatry* 40(3):23-31, 1979.

The therapeutic potential of psychiatric consultation is discussed with reference to the four stages of patient emotional reactions to physical illness. The first reaction stage is anxiety; this is best dealt with via explanation, clarification, and realistic reassurance. In cases of excessive initial anxiety with danger of ego

disorganization, there is usually an underlying preexisting neurosis; a suppressive approach, including tranquilizing medication, is usually desirable. In the defensiveness/bargaining stage, a consultee-oriented approach to psychiatric liaison is recommended in which the psychiatrist interprets patient symptomatology and personality to staff in order to obtain a consistent approach toward the patient. During the relative acceptance stage, typical problems may include patient overcompliance, withdrawal, passive aggression, or depression. The therapeutic goal should be restoration of hope and, as in previous stages, maintenance of self-esteem. Depression, anxiety, and somatic complaints associated with secondary gain may appear during the convalescence and recovery stage. A resocialization program involving patient and family is advised. (abs.)

214. Shraberg, D. Psychiatric disturbances seen in primary care: When to treat and when to refer. *Southern Medical Journal* 74(4):438-443, 1981.

Recent advances and changes in diagnosis and treatment of various psychiatric disturbances have both increased cooperation between psychiatrists and primary care physicians and better integrated psychiatry with the remainder of medicine. With increasing emphasis on the holistic approach to patient care and more appreciation of emotional components of various physical illnesses, the primary care physician now must both understand and use various pragmatic psychiatric concepts. To the benefit of the patient, the primary care physician, and the psychiatrist, this integration of psychiatry with medicine appears to be growing. Thus an overview of the major psychiatric disturbances seen by the primary care physician, as well as guidelines on when to treat and when to refer these problems, should be useful.

215. Small, E.C., and Mitchell, G.W., Jr. Practical aspects of full-time liaison psychiatry in gynecology. *Journal of Reproductive Medicine* 22(3):151-155, 1979.

A full-time liaison psychiatrist can work within a department of obstetrics and gynecology. The full-time position described here includes administrative, clinical, teaching, and research aspects within a general hospital affiliated with a medical school. The liaison role can be established within a department outside psychiatry where medical and psychologic treatment can be rendered to patients simultaneously and the mediating role between psychiatry and medicine is truly a viable phenomenon.

216. Soloff, P.H. The liaison psychiatrist in cardiovascular rehabilitation: An overview. *International Journal of Psychiatry in Medicine* 8(4):393-402, 1978.

An overview of the role of the liaison psychiatrist in cardiovascular rehabilitation is presented. Depression, anxiety, and fear of recurrence following myocardial infarction often lead to disability in excess of the actual cardiac impairment in a large number of patients. The high social, economic, and emotional costs of psychogenic cardiac invalidism have stimulated the implementation of cardiac rehabilitation programs which combat psychological sequelae through physical conditioning and intensive education. The conflicts of the postinfarction patient and their management by rehabilitation teams are presented from the perspective of the psychiatrist as group leader and team member. Through individual consultation, group therapy sessions, and team meetings which address psychological issues of convalescence, psychiatric liaison can prove productive in cardiovascular rehabilitation. (abs.)

217. Steinberg, H.; Torem, M.; and Saravay, M. An analysis of physician resistance to psychiatric consultation. *Archives of General Psychiatry* 37(9):1007-1012, 1980.

Chart rounds were conducted with house and nursing staffs to identify those patients with prominent psychiatric problems relating to hospitalization. It was found that physician resistance to consultation was involved in more than 50 percent of cases not referred, usually because the physicians believed that there was no psychiatric problem or that psychiatry could not help, and less often because the physician thought that the patient might become upset or the patient-doctor relationship would be destroyed. The basis of the physicians' resistance was found to be unjustified in 26 of 29 patients seen, and 23 of these patients were judged to have been helped by the psychiatrist. The importance of further close collaboration between the psychiatrist and the treating physician to improve the care of patients reacting to physical illness and hospitalization is pointed to by the results. (abs.)

218. Stewart, R.S., and Stewart, R.M. Neuropsychiatric aspects of chronic renal disease. *Psychosomatics* 20(8):524-531, 1979.

Some neuropsychiatric aspects of chronic renal disease are presented. Chronic renal disease, hemodialysis, and renal transplantation may be accompanied by a variety of derangements of high cortical functioning, mental processes, and behavior. Many treatable toxic metabolic, degenerative, and structural processes may occur as a result of the progression of the renal disorder itself,

associated medical conditions, or secondary neurologic complications. Associated behavioral changes may easily be confused with functional disorders. It is concluded that an understanding and awareness of these entities is important for the consulting psychiatrist in order to properly diagnose and care for the renal patient who shows disturbances in behavior. (abs.)

219. Strain, J.J.; Vollhardt, B.R.; and Langer, S.J. A liaison fellowship on a hemodialysis unit. A self-funded position. *General Hospital Psychiatry* 3(1):10-15, 1981.

The practice of liaison psychiatry has from its inception been hampered by an inadequate or nonexistent funding base. A model is presented for funding an authentic liaison training program, fully supported by consultation-generated revenue. A specific description of the liaison teaching unit is given to illustrate how the following objectives of the program were successfully met: provision of comprehensive biopsychosocial care, dissemination of psychological skills and knowledge to nonpsychiatrist staff, training of the liaison fellow, and generation of sufficient revenue to offset costs.

220. Styles, W.M. Childhood behaviour disorders in general practice: A review. *Journal of the Royal Society of Medicine* 72(10):766-772, 1979.

An overview of childhood behavior disorders in general medical practice is presented. Serious psychiatric illness and mental handicap in children are briefly discussed, and the definition, classification, and incidence of behavioral disorders in children in Great Britain are reviewed. Genetic, development, and medical predisposing factors, including child's parents' and siblings' medical history, are delineated. Social factors in childhood behavior disorders are also discussed including family/marital discord, overcrowded housing and other environmental stresses, academic performance, and adoption. The role of the general practitioner in working with behavior disordered children and their families, with other support agencies, and in consultation or psychiatric referral is discussed. The need for professional training in this area is noted.

221. Taylor, G., and Doody, K. Psychiatric consultations in a Canadian General Hospital. *Canadian Journal of Psychiatry* 24(8):717-723, 1979.

A survey of psychiatric referral patterns on the inpatient wards of a university teaching hospital over a 5-year period is reported. The most frequent requests were for assistance with diagnostic problems and the management of depression. The majority of

consultation patients had concurrent physical and psychiatric diagnoses which could be treated in the medical setting. Factors influencing the referral process are discussed, and the limitations of consultation/liaison psychiatry are acknowledged. Changes in medical and nursing education are suggested to promote the wider practice of comprehensive patient care.

222. Wain, H.J. Hypnosis on a consultation/liaison service. *Psychosomatics* 20(10):678-689, 1979.

The rationale for, establishment of, and use of hypnotic intervention on a consultation/liaison service are discussed and illustrated by case histories. It is noted that as a therapeutic and research tool that links physiologic and psychological aspects of the patient, hypnosis fits in very well with consultation/liaison psychiatry. Hypnosis can play a valuable role in meeting the goals of a psychiatric consultation/liaison service, including patient care, teaching and research activities, and the strengthening of links between psychiatry and medicine. (abs.)

223. Wallbridge, D.C. The role of a consultant psychiatrist in a residential caring establishment (a personal view). *Bulletin of the Royal College of Psychiatrists (London)*. Oct. 1978. pp. 173-175.

A model for the role of a consultant psychiatrist providing staff support in a residential caring establishment is presented. The proper position for such an individual is that of a true consultant, available to the social work staff for consultation about their work. To be effective, the psychiatrist must have access to multiple sources of information. Often the head of the establishment must demand that staff provide the psychiatrist with the required information. It is emphasized that the psychiatrist is not a personal psychiatrist for any individual, but rather a consultant for all the patients. The psychiatrist's role in a residential care situation is primarily educational, and he or she can contribute to in-service training programs conducted at the institution.

224. Weathers, O.D., and Bullock, S.C. Therapeutic group home care for adolescent girls: An interagency development. *Journal of the National Medical Association* 70(5):331- 334, 1978.

An attempt to provide services to some disturbed adolescents in an interagency therapeutic group home is described. The background and development of the home are discussed. The program, which employs the services of a houseparent, a social worker, a project director, and a part-time consulting psychiatrist and group therapist, is reviewed. The nature of the problems encountered in

group living is examined and difficulties in staffing such a home are identified. Recommendations are made for the conditions which would exist in the establishment of group homes using the interagency approach. Benefits derived from placing children in an interagency-operated therapeutic group home are enumerated.

225. Weddington, W.W., Jr. Dementia dialytica. *Psychosomatics* 19(6):367-370, 1978.

The symptoms, course, and possible causes of dementia dialytica, a progressive, usually fatal, organic neurological disorder that occurs in some hemodialysis patients, are described. It is noted that the syndrome begins with stuttering and progresses to memory impairment, psychoses, motor seizures, incapacitation, and death. Abnormal EEGs have also been observed. It is asserted that the behavioral changes these patients undergo may require psychiatric consultation for diagnosis, management, and treatment. Two case histories and their psychiatric evaluations and treatments are described. It is concluded that patients undergoing dialysis appear to be at risk for the syndrome, and that the number of people affected by this syndrome is increasing. (abs.)

226. Wildbolz, A. Consultation and liaison psychiatry--A contribution to the holistic thinking in medicine. *Schweizer Archiv fur Neurologie, Neurochirurgie und Psychiatrie* 131(1):81-88, 1982.

After some introductory remarks about consultation and liaison psychiatry, the psychiatric consultation and liaison service in the general university hospital of Bern is presented. It has a statistically expressible exterior activity and an interior activity. It gives its contribution to holistic medical thinking in the fields of patient care, teaching, research, expertising, and public relations. Problems of integration of consultation and liaison psychiatry and their possible solutions are discussed on the basis of two other studies by this author. The importance of creating psychiatric services in general hospitals is emphasized.

227. Wilson, L.G. Community psychiatry in Oceania: Fifteen months' experience in Micronesia. *Social Psychiatry* 15(4):175-179, 1980.

Fifteen months' work as the only psychiatrist for the 120,000 people of the Trust Territory of the Pacific Islands (Micronesia) is described. Community psychiatry principles and approaches had to be adjusted to the practical realities of attempting to serve the isolated and sparsely populated islands of Micronesia. The major thrust of the program was giving clinical consultation/supervision and teaching doctors and paraprofessionals basic concepts of

mental health. Psychiatric assistance to courts and jails regarding psychiatrically disturbed people was another significant effort. In all work in Micronesia, it was found that a teaching component could easily be built in, since basic psychological and psychiatric knowledge was needed and desired by the Micronesians. (abs.)

228. Wise, T.N., and Berlin, R.M. Burnout: Stresses in consultation/liason psychiatry. *Psychosomatics* 22(9):744-751, 1981.

Psychiatrists involved in consultation/liason work may be subjected to unique stresses--including role ambiguity and role conflict--in addition to the stresses that foster burnout in other health care professionals. This paper examines various areas of vocational difficulty and proposes coping strategies.

229. Wynne, A.R. Movable group therapy for institutionalized patients. *Hospital and Community Psychiatry* 28(8): 516-519, 1978.

Chronic psychotic inpatients at the Rochester, New York, Psychiatric Center participated in a normalization program in which group therapy sessions were held in parks and restaurants in the community. The only guideline given patients was that no one observing the group should have reason to think members were from the State hospital. The patients were transported in an unlabeled car. The therapist consulted with staff before and after outings, thus providing integration with the overall treatment plan. After 1 year, 20 of the original 40 patients had been discharged; after 3 years, only 8 were still hospitalized. The dynamics of observed emotional growth and symptom relief are emphasized, and cautions about interpretation of the rate of discharge are examined. (abs.)

230. Yager, J.; Pasnau, R.O.; and Lipschultz, S. Professional characteristics of psychiatric residents trained at the UCLA Neuropsychiatric Institute, 1956-1975. *Journal of Psychiatric Education* 3(1):72-85, 1979.

Psychiatrists who trained at the University of California, Los Angeles, Neuropsychiatric Institute residency program from 1956 to 1975 were surveyed about their current professional activities. The large majority lead diversified careers. Less than half of responding graduates spend more than half of their professional time in office private practice and more than three-fourths have medical school appointments. Fewer recent graduates have engaged in psychoanalytic training and more have taken postresidency subspecialty fellowships. Recent graduates have been more

involved with administrative, consultative, and hospital work than earlier graduates. They also more frequently report marital/family problems, socioeconomically disadvantaged clients, minority group patients, epilepsy, and group therapy method as very or moderately important in their work. Factors contributing to changing practice patterns are discussed. (abs.)

See also:

14, 17, 18, 19, 20, 21, 22, 24, 25, 26, 30, 275, 311, 312, 317, 318, 322, 326, 335, 341, 343, 345, 350, 356, 359, 360, 361, 366, 371, 376, 379, 380, 382, 384, 386, 388, 390, 391, 394, 395, 396, 397, 401, 404, 408, 409, 410, 411, 413, 414, 416, 417, 418, 420, 421, 424, 433, 434, 438, 442, 443, 451, 472, 475, 480, 481, 485, 486, 488, 490, 493, 496, 501, 503, 508, 509, 510, 515, 518, 519, 520, 530, 533, 537, 538, 539, 543, 545, 548, 550, 555, 557, 559, 562, 563, 565, 568, 569, 575, 577, 578, 582, 586, 588, 589, 590, 591, 593, 594, 596, 599, 601, 605, 606, 609, 611, 615, 618, 622, 624, 625, 631, 632, 635, 638, 640, 641, 646, 648, 649, 650, 656, 657, 659, 664, 668, 678, 683, 710, 732, 803, 808, 813, 814, 820, 821, 822, 825, 829, 834, 836, 839, 844, 852, 854, 855.

Psychology

231. Allen, J.G. The clinical psychologist as a diagnostic consultant. *Bulletin of the Menninger Clinic* 45(3):247-258, 1981.

The central role of the clinical psychologist continues to be to conduct testing and to provide clinical consultations. The importance of psychodiagnostic testing, the clinical skills of the consulting psychologist, and cooperation between therapist and consultant are stressed.

232. Alpert, J.L., and Trachtman, G.M. School psychological consultation in the eighties: Relevance for the delivery of special services. *School Psychology Review* 9(3):234-238, 1980.

Discusses three ways in which the consultative role of the school psychologist will be affected by the Education of All Handicapped Children Act, PL 94-142: increasing time allotted to psychoeducational assessment, increasing time allotted to traditional consultative services, and increasing environmental consultation. Professional judgment should determine how professional time is balanced among the various activities.

233. Amos, I.E. Child advocacy and the adversary system: Round peg in a square hole? *Journal of Clinical Child Psychology* 10(1):56-68, 1981.

Describes a recent adoption/custody decision of serious legal implications, with particular focus on the psychologists' role, highlighted by the appearance of six psychologists as "experts" in the case. An argument for use of the consultation model, implemented by identifiable child specialists, in child custody determination is presented as an alternative to the multiple expert witness approach.

234. Bamgbose, O.; Smith, G.T.; Jesse, R.C.; and Groth-Marnat, G. A survey of the current and future directions of professional psychology in acute general hospitals. *Clinical Psychologist* 33(2):24-25, 1980.

Utilization of professional psychologists within the acute general hospital setting was examined in a survey of 36 hospital administrators in 2 California counties. Analysis of the 17 completed questionnaires (47 percent response rate) indicated that 40 percent of respondents agreed with the concept of having an organized psychology department within the hospital, 26 percent indicated they had such a department, and 26 percent indicated they were interested in establishing one. Respondents indicated that they utilized professional psychologists in the areas of organization development and staff training, psychosomatic medicine, and care of the terminal/dying patients (33 percent); for provision of services to preoperative and postoperative, substance abuse, and family practice patients (26 percent); and in admission consultation (20 percent). Expectations of respondents indicated a growing role for professional psychologists in the acute general hospital.

235. Brantley, H.T.; Stabler, B.; and Whitt, J.K. Program considerations in comprehensive care of chronically ill children. *Journal of Pediatric Psychology* 6(3):229-237, 1981.

Focuses on four areas of program development that are presented as integral parts of the collaboration process between medicine and psychology: case consultation, liaison, research, and training. Potential differences in the collaborative process are noted, and corrective strategies are suggested. Emphasis in case consultation and research is placed on understanding the overlooked phenomenon of successful adaptation of chronically ill children and their families. Training requirements are specified as extending beyond traditional clinical child psychology and pediatric psychology. It is concluded that there is need for prototypical psychosocial programs in comprehensive care for this population.

236. Cameron, C. Expanding vocational placements for marriage counselors. *Marriage and Family Counselors Quarterly* 12(4):25-34, 1978.

Factors contributing to the gap between the need for marriage counselors and their underemployment as professionals are discussed. Latent opportunities are disclosed for vocational placement which challenge long held assumptions about the place of marriage and family counselors. It is suggested that trained relationship counselors are essential in the fields of mental, physical, social, and moral health in which the problems of an individual can mean trouble for a family. It is concluded that marriage counselors have a role in a network of professionals by sharing resources, consultation, and referrals. (abs.)

237. Crewe, N.M. The psychologist's role in sexual rehabilitation of people with physical disabilities. *Sexuality and Disability* 2(1):16-22, 1979.

The contribution of psychologists to the sexual rehabilitation of individuals with physical disabilities is discussed. Psychologists are contributing in the areas of direct counseling services to patients and families, consultation with other health professionals, education, advocacy, and research. The work of psychologists is characterized by the philosophy and skills imparted by their training. Influential factors in their work include knowledge of human learning theory, skill in implementing programs of behavioral change, research orientation toward the identification of needs and provision of services, training in personality theory and the complex process of adjustment, and highly developed interviewing skills. (abs.)

238. Drotar, D. Training psychologists to consult with pediatricians: Problems and prospects. *Journal of Clinical Child Psychology* 7(1):57-60, 1978.

Experiences with the training of clinical psychologists to consult with pediatricians are reviewed. Disparate training backgrounds and problematic models of collaboration are seen as barriers to learning effective consultation. To meet these potential obstacles, training approaches should emphasize observation of staff interaction, participation in viable consultation structures, and intensive clinical training. With optimal supervision, psychologists at a variety of levels can be trained to consult successfully with pediatricians. (abs.)

239. Elardo, R. Preschool psychology: A personal view. *School Psychology Review* 8(3):311-318, 1979.

Describes the author's experience in three "nontraditional" roles as a school psychologist in early childhood education programs--those of consultant, program developer, and researcher. It is argued that both school psychology and early childhood education will benefit if school psychologists are given the opportunity to function in a variety of roles.

240. Fairchild, T.N. The school psychologist's role as an assessment consultant. *Psychology in the Schools* 19(2):200- 208, 1982.

Proposes a strategy for school psychologists for broadening their range of services that involves minimizing their diagnostic role by becoming an assessment consultant on the Child Study Team. Areas of broader service include instrument selection, training of team members, staffing, assessment development, team evaluation, and documentation.

241. Finley, J.R. The psychologist consultant's role in the State vocational rehabilitation agency. *Journal of Rehabilitation* 45(1):45-47, 1979.

Arizona's State vocational rehabilitation program has established a role for psychologist consultants with duties comparable to those of State agency medical consultants. This article describes the development of the psychologist/consultant role, its functions, and some of the results thus far.

242. Gandy, G.L. The development of a psychological-vocational evaluation referral instrument. *Psychology* 16(2):47-50, 1979.

Development of a psychological/vocational evaluation referral instrument is described. An initial referral research instrument was created based on the literature and opinions of experts in the field of vocational rehabilitation. A rating scale, designed to obtain both quantitative and qualitative data, was constructed and evaluated by 80 rehabilitation counselors and 10 consulting psychologists. Results suggest that an effective referral instrument could capitalize upon the skill and training of the professional counselor in contributing to a more useful psychological/vocational evaluation report by the consulting psychologist. The quantitative and qualitative evaluation data were used to revise the initial research referral instrument. (abs.)

243. Gibbins, S. Public Law 94-142: An impetus for consultation. *School Psychology Review* 7(3):18-25, 1978.

Describes four common modes of consultation most adaptable to school psychology and discusses how consultation may fulfill needs mandated by Public Law (PL) 94-142. These models include mental health consultation, organizational process, information giving, and systems intervention; the commonality among them is that the consultant is the person outside the situation in which the problem occurs. Previous research from which these models are taken is cited. The new priorities mandated by PL 94-142 can possibly encourage the consultative role to be the primary activity of school psychologists (which, according to the literature, has not been so in the past). Regarding assessment procedures, evaluations must be administered in the child's native language, be validated for the specific purpose for which they are used, and be responsive to specific educational needs. Individual educational plans should be formulated by multidisciplinary teams and implemented through an ongoing problem-solving relationship. The role of school psychologist in formative evaluation, intervention procedure, and/or modification of the feedback system itself is indicated. To ensure that "mainstreaming" is a positive action, psychologists can contribute skills and knowledge concerning effective growth and group process, and, additionally, train and educate parents and teachers. The ongoing formative evaluation approach illustrated by PL 94-142 potentially can improve educational environments for all children.

244. Green, K., and Fine, M.J. Family therapy: A case for training for school psychologists. *Psychology in the Schools* 17(2):241-248, 1980.

A rationale and methodology for family involvement in psychoeducational identification, assessment, and intervention programs are presented which underscore the need for school psychology training programs to respond programmatically to the training needs of their students in understanding and working with families. A family systems approach is adopted and presented in the form of key questions concerning some important family dynamics related to coalitions, collusions, and triangulations; family boundary functions (enmeshment/disengagement); differentiation of self and system; establishment and maintenance of sex roles, social roles, and identities; family interactions with agencies and the community; and family maintenance and change. Applications of this framework in the school setting are discussed in terms of the initial interview, short-term family therapy, consultation, individual pupil counseling, and the classroom and school as a family system. (abs.)

245. Gross, M., and Huerta, E. Functional convulsions masked as epileptic disorders. *Journal of Pediatric Psychology* 5(1):71-79, 1980.

The need for psychological consultation to distinguish those patients that seemingly might suffer from epilepsy but actually suffer from functional convulsions is discussed. Information is presented on 19 cases found to have a functional disorder based on emotional disorder during a 2-year period of consultation to the Epileptic Diagnostic Center for Children in Cleveland. The importance of a thorough history obtained from the patient and family about the environmental background is emphasized. (abs.)

246. Grzesiak, R.C. Psychological services in rehabilitation medicine: Clinical aspects of rehabilitation psychology. *Professional Psychology* 10(4):511-520, 1979.

The role of the psychologist in a rehabilitation medicine setting is reviewed, with special emphasis on the application of the traditional clinical and counseling skills of psychological assessment, counseling, and psychotherapy to psychological problems encountered by the physically disabled. Briefly reviewed are the rehabilitation perspective, issues of adaptation and personality, psychodiagnostic and psychotherapeutic consultation, and behavioral principles. Other almost totally neglected areas of the psychologist's role in rehabilitation, such as research, consultation/liaison, in-service training and group and family therapy, are also described. Some of the ways that psychology in rehabilitation is unique are mentioned, as well as a number of ways in which the providing of psychological services to the disabled does not differ from psychological services in other settings.

247. Haas, L.J., and Weatherley, D. Community psychology in the library: Potentials for consultation. *American Journal of Community Psychology* 9(1):109-122, 1981.

Describes several themes that influence libraries' conceptions of their place in the community, conflicts that can hamper libraries' realization of their potential, and methods that the community psychologist might use in consulting with libraries. Examples from a staff development project in an academic library are presented.

248. Hannafin, M.J., and Witt, J.C. System intervention and the school psychologist: Maximizing interplay among roles and functions. *Professional Psychology: Research and Practice* 14(1):128-136, 1983.

School psychologists face unique challenges in the determination of professional roles and responsibilities. Although many popularly accepted roles have been endorsed by members of the profession, insufficient attention has been directed toward system influences and the effects of such influences on the functions of school psychologists. The purposes of the present article are to present a conceptual framework for understanding systems and to present a model for affecting system-level interventions. School psychologists are encouraged to consider the broader implications of their roles and responsibilities within educational systems and to maximize the value of traditional roles by seeking both individual and system-level change.

249. Hartlage, L.C., and Hartlage, P.L. Clinical consultation to pediatric neurology and developmental pediatrics. *Journal of Clinical Child Psychology* 7(1):19-20, 1978.

The role of the clinical child psychologist in pediatric neurology is discussed. It is asserted that physicians whose primary focus of practice is with developmentally disabled children have a special need for psychological consultation. While referrals to this sort of practice are primarily for physical handicaps such as epilepsy or motor handicaps, the majority of such patients will have cognitive or behavioral problems as well. The clinical child psychologist's skill in screening and individual assessments, counseling, behavioral modification, educational and vocational planning, and objective assessment of various treatment modalities can enhance the quality of patient care in a complementary rather than a competitive manner. (abs.)

250. Holahan, C.J., and Bell, K.F. An application of ecological methods in community psychology: Assessing the functioning of an innercity park. *Journal of Community Psychology* 6(4):309-311, 1978.

A case study involving an evaluation of the functioning of a new innercity park by community psychologists, employed by a city department of parks, is discussed. The findings support the potentially valuable role of ecological methods in community psychology practice in terms of (1) providing a means for evaluating the behavioral effectiveness of designed settings, (2) affording data that are of practical utility, (3) furnishing a link between theory and practice in community psychology, and (4) supporting a

consultation process that is congruent with community psychology's guiding values. (abs.)

251. Jason, L.A.; McCoy, K.; Blanco, D.; and Zolik, E.S. Decreasing dog litter: Behavioral consultation to help a community group. *Evaluation Review* 4(3):355-369, 1980.

A collaborative effort between an ad hoc community group and a university-based research team is described. The community group formed to ameliorate a health and esthetic problem, the excessive accumulation of dog feces deposited on sidewalks and lawns. The community group identified the target problem and contributed resources and labor for the mounted interventions, with the community psychologists providing training in relevant behavioral technologies and evaluating the interventions' efficacy. Over a 9-month period two interventions were implemented and levels of dog litter were significantly reduced with the onset of the second intervention. Advantages in working with informal support systems within communities are delineated. (abs.)

252. Kurpius, D.J. Defining and implementing a consultation program in schools. *School Psychology Review* 7(3):4-17, 1978.

Defines consultation services provided by school psychologists, modifying the traditional role image, and presents a plan to develop and implement a newly defined consultation program. Consultation, newly defined, is triadic (three-party), voluntary, interdependent, power balanced, work related, problem oriented, and mutually beneficial for client, consultee, and consultant. Change variables to consider when consulting are discussed in light of previous work: Walton and Warwick (1973), Lewin (in Bennis et al. 1976), Bandura (1978), and Leavitt (1973). A force field analysis in which block and support forces are examined and dealt with is suggested. The three important change variables are as follows: (1) change, although normal and developmental, is often met with resistance; (2) change viewed from systems or behavioral point of view still inevitably involves reciprocal interaction between environment and behavior; (3) both supporting and resisting forces exist for each change goal. Four different approaches to consultation are presented and should be utilized according to type of help that is required: provision, prescription, collaboration, and mediation. Nine stages representing the consulting process are pre-entry, entry, gathering formation, defining the problem, determining the problem solution, stating objectives, implementing the plan, evaluating, and terminating. To implement the program, the consultant should be inquiry oriented, collaborative in style, aware and accepting of blocking and supporting forces, and aware of global effect of systems approach.

253. Lavoegie, M. Psychologist's role in promotion processes in large industrial organizations. *Bulletin de Psychologie* 33(4-11):425-430, 1979-1980.

The assessment protocols for a group of promoted and unpromoted first-level managers are compared to determine the validity of selection procedures. The diagnostic procedure, in six stages requiring 7 to 8 hours, was conducted by a consulting psychologist and included measures of (1) intelligence (logic, abstraction, and reasoning), (2) reading (vocabulary and comprehension), and (3) personality. A biographical interview was also conducted. Results indicate that decisions to promote or not promote were related to aptitudes. Personality characteristics had little influence on the decision.

254. Leventhal, A.M., and Magoon, T. Some general principles for university counseling centers. *Professional Psychology* 10(3):357-364, 1979.

General principles for university and college counseling centers are presented together with their rationale and illustrations, where appropriate. The principles relate to professional core staffing and their relationship to the academic milieu; relevance of services to the student body; focus on an education model of behavior rather than a model of disease; confidentiality; theoretical orientations; consultations; direct observations of professional staff's counseling; relationship of the center to its environment; staff development training; service evaluation and innovation; peer counseling programs; and the role of the central administration.

255. Lolli, A., Jr. Implementing the role of the school psychologist. *Psychology in the Schools* 17(1):70-75, 1980.

Implementation of any of the many potentially diverse facets of the school psychologist's role is discussed. These facets may include educational and psychological assessment, individual and group intervention, referral and consultation for teachers or parents, liaison with social service agencies, and child advocacy. However, in many school districts the conception of the school psychologist's role is limited to that of psychometrist and counselor involved in individual interventions with students in a setting divorced from the classroom. Suggestions are made pertaining to practitioner-initiated activities which can inform administrators, teachers, parents, and students of the range of potential services available. Assessing the effectiveness of role implementation through formative evaluation or process evaluation is discussed. (abs.)

256. Melton, G.B. The psychologist's role in juvenile and family law. *Journal of Clinical Child Psychology* 7(3):189-192, 1978.

Areas of judicial practice pertaining to children in which psychologists can offer significant expertise are identified, and suggestions for a due process model of psychological practice in juvenile and family law are proposed. Psychologists can contribute to the legal process through research on children's understanding of legal proceedings and the impact they have on children. In both policy and case consultation, due process demands that psychologists identify the bases of their conclusions and the limits of their expertise. It is particularly important to identify the interests one is representing in the legal system. In some instances, a treatment ideology may mystify the legal process. Psychologists might be most effective in consultation on cases prior to their reaching court. (abs.)

257. Pitcher, G.A. Pleasure/pain and primary physicians. *Journal of Clinical Psychology* 7(1):29-32, 1978.

The role of the department of psychological services in a general hospital is outlined. Psychological assessment, evaluation, and short-term supportive counseling services are provided for non-psychiatric primary care physicians in a general hospital. Inpatients and outpatients are seen for psychomedical problems. Complaints cover a broad range of symptoms which include fainting, headache, back pain, school learning problems, confused thought patterns, vomiting, and weight loss. Age of the patients extends from pediatrics to geriatrics. Other services include conferences with nursing units, hospital inservice education, consultation to community groups such as rehabilitation services, Head Start, and developmental disability centers. Education of the nonpsychiatric primary care physicians is recommended. (abs.)

258. Quirk, M.P.; Scherz, R.G.; and Moss, N. Psychosocial consultation in a pediatric health center as an entry point to a youth services system. *Journal of Clinical Child Psychology* 7(1):32-36, 1978.

The role of psychosocial consultation in referring pediatric hospital medical patients to community child psychosocial services is examined. The categories of children appropriately referred to the Behavioral Sciences Service in a pediatric hospital setting, the nature of services offered through the Behavioral Sciences Service and the coordinated availability of the Youth Services System sponsored by a community mental health center as a unique dispositional resource are identified. The role of the

primary physician in this scheme and directions for the future are discussed. (abs.)

259. Rae, W.A., and Hendelman, J.V. Nursing consultation groups: A mental health intervention in pediatrics. *Journal of Clinical Child Psychology* 7(1):84-86, 1978.

The role of the consultant psychologist in training pediatric nurses in psychological skills is discussed. With the help of the clinical child psychologist consultant and the institution of nursing consultation groups, the nurse may obtain help in dealing with the mental health difficulties of pediatric patients as well as their own staff problems. The three purposes of nursing consultation groups are enumerated as sharing of feelings, skills training and traditional case consultation, and organizational development and team building. (abs.)

260. Randolph, D. The behavioral consultant in the school. *American Journal of Community Psychology* 7(3): 353-356, 1979.

Suggests how the mental health professional as consultant may multiply the effects of his or her services by training school specialists to serve as on-the-job consultants to teachers for preventive mental health intervention.

261. Rhodes, W.C. Beyond theory and practice: Implications in programming for children with emotional disabilities. *Behavioral Disorders* 5(4):245-263, 1980.

Cultural relativity and the ecological nature of the deviant condition are examined. It is argued that deviance is in the eye of the beholder, that normality and abnormality are culturally determined. Historical, psychological, and cultural studies are cited which demonstrate the effect of the physical and cultural environment on the individual. What is left then to professional service is a number of healing techniques: consultation, child advocacy and parental advocacy, deinstitutionalization, technical assistance, and network construction. To be a healer, it is suggested, one must first honestly confront the knowledge that perfectability is not possible but is a cultural myth and that the professionals' right to work with clients to change them is also a product of the culture.

262. Ruttle, K. Two alternative roles for the school psychologist in the treatment of emotionally disturbed and autistic children. *Psychology in the Schools* 18(4): 467-470, 1981.

The first alternative role is behavior management of disturbed children either by consultation to program staff or by direct work with the child, as well as support of staff through continuous feedback of classroom behavior management techniques. The second approach encompasses all of the first approach, in addition to the psychologist's serving as coordinator for the program and thereby assuming greater responsibility for cooperation between the school and the home, as well as for ongoing program development. A major difference in these two roles of the school psychologist, compared to the traditional role, is an intense involvement with a small number of children and a high level of input into the management, structure, and techniques used in a small number of classrooms. A model is presented for both of the two native approaches for the school psychologist. The model includes (1) a format for ongoing behavior assessment, (2) suggestions for structure of teacher-psychologist feedback sessions, (3) methods of school and home cooperation, and (4) a proposal for a horizontal administrative structure of programs for emotionally disturbed and autistic children. The concept that is advocated is a team of professionals (teacher and psychologist) planning for the holistic development of the child.

263. Sachs, R.H.; Eigenbrode, C.R.; and Kruper, D.C. Psychology and dentistry. *Professional Psychology* 10(4): 521-528, 1979.

A description of the functions of the department of behavior science in one dental school is provided to illustrate the contributions of psychology to dental education. Through formal course offerings and through consultation, dental students are taught (1) to collect a complete history, (2) to modify behavioral resistance to treatment resulting from fear or anxiety, (3) to determine how the patient's behavioral status will influence the selection and course of dental treatment, (4) to present a treatment plan to a patient in a manner that will elicit the patient's cooperation, (5) to help motivate the patient to practice methods for preventing dental disease, and (6) to deal effectively with the child, the adult, and the geriatric patient. The content of courses is described and specific forms of psychological distress in which assistance is provided are described. A brief history of the collaboration between psychology and dentistry is offered, and a model is suggested for training psychologists to function in a dental environment.

264. Senft, L.B., and Snider, B. Elementary school principals assess services of school psychologists nationwide. *Journal of School Psychology* 18(3):276-282, 1980.

A nationwide survey of 400 elementary school principals assessed their opinions regarding services of school psychologists. Principals indicated on the one-page questionnaire that the school psychologist was most helpful when providing the traditional services of psychological testing, personality and emotional assessment, consultation, and screening. Changes desired by principals were more time from the school psychologist and an increase in individual and group counseling, preventive mental health, and inservice training. No gross alterations to existing school psychology services were indicated. (abs.)

265. Shore, K. The school psychologist as classroom-based consultant. *New Jersey Journal of School Psychology* 1:74-83, 1982.

Argues that a consultation-oriented approach to school psychology is more effective and efficient than the traditional psychodiagnostic approach. The psychometric approach continues to predominate despite the criticisms of questionable validity, minimal instructional utility, problems in teacher-psychologist communications, inefficient use of professional time, and school psychologist dissatisfaction. The advantages of the consultation model include its efficiency, receptivity by school personnel, effectiveness, and appropriateness in meeting legal mandates. The stages of consultation are pre-entry, entry, information gathering, problem definition, problem solution, plan implementation, evaluation, and termination.

266. Stabler, B. Emerging models of psychologist-pediatrician liaison. *Journal of Pediatric Psychology* 4(3):307-313, 1979.

The basic mechanisms, objectives, and applications of three emerging models of the psychologist/pediatrician liaison are described. They are process consultation, a collaborative liaison in which patient care and treatment planning responsibilities are shared; process-educative consultation in which the pediatrician takes the role of primary care provider with the psychologist acting as a supportive source of information and technical skill; and the resource consultation, in which the primary emphasis is on transmission of data between pediatrician and psychologist. It is proposed that consultation/liaison skills are a necessary component in the professional repertoire of the pediatric psychologist. (abs.)

267. Stewart, K.J., and Medway, F.J. School psychologists as consultants: Issues in training, practice, and accountability. *Professional Psychology* 9(4):711-718, 1978.

Issues in the development of a consulting indirect service role for school psychologists are discussed. The need for training school psychologists in consulting skills, the obstacles encountered in the initiation of consultative relationships, and methods for assessing efficiency and effectiveness of consultative activities are considered. It is suggested that school psychologists take action to legitimize their consultation roles through negotiation with school officials, that they select their initial cases with an eye to increasing the chances for successful outcomes, that they modify the referral process to avoid excessive testing, and that they seek to demonstrate the benefits of a consultative model of service. (abs.)

268. Stewart-Lester, K.J. Increased consultation opportunities for school psychologists: A service delivery model. *Psychology in the Schools* 19(1):86-91, 1982.

Describes a model of delivery of services that enables school psychologists to meet testing demands while initiating a broad range of consultative services. Requirements of the model include (1) having funds available for contract testing, (2) having conferences with teachers prior to formal referral of children, and (3) having qualified contract evaluators available. Benefits and obstacles to be expected in implementing the model are discussed.

269. Tidwell, R. Informal assessment to modify the role and image of the school psychologist. *Psychology in the Schools* 17(2):210-215, 1980.

The upgrading of the school psychologist's role and image through the use of nontraditional/informal assessment procedures in psychoeducational diagnosis and placement decisionmaking is discussed. It is suggested that informal procedures can be specifically constructed to facilitate the design of effective dimension/modality-specific classroom sequences; can be taught to teachers, together with remediation strategies, thus facilitating a consultation role rather than a testgiver role of the school psychologist; and can be adapted to meet the needs of parents and used to involve parents more directly in educational programming decisions. (abs.)

270. Tuma, J.M., and Schwartz, S. Emerging roles of the psychologist and the primary health care provider. *Journal of Clinical Child Psychology* 7(1):2-4, 1978.

The emerging role of the psychologist and the primary health care provider are discussed in view of their interrelationship. It is asserted that a growing awareness of the role of emotional factors in physical illness has led to an expanded role for psychologists and psychological training in primary health care. The areas addressed by "journal" articles in the present issues are identified. Among the subjects covered are psychological consultation as a method of training primary health care providers, the work of psychologists in health care settings, the growing psychological roles for primary care providers, and training for both clinical psychologists and primary practitioners.

271. Webster, R.P. Advisory committees: Progress and perspectives. *Bulletin of the British Psychological Society* (London) 31:194, 1978.

A summary is provided of a paper on progress and perspectives of advisory committees with the National Health Service, presented at the 1978 Annual Conference of the British Psychological Society. Also reported is a survey conducted throughout England and Wales in 1977 of advisory machinery for clinical psychologists. Advisory functions, staff consultative arrangements, and other committee functions undertaken by clinical psychologists are differentiated. Finally, future prospects and the extent to which the advice of clinical psychologists is likely to influence the services in which they work are discussed. (abs.)

See also:

1, 2, 3, 4, 15, 16, 27, 28, 29, 32, 36, 86, 307, 308, 320, 328, 332, 337, 338, 343, 344, 370, 378, 387, 392, 400, 408, 410, 412, 422, 426, 435, 436, 440, 441, 453, 454, 461, 471, 472, 474, 476, 477, 483, 489, 495, 501, 511, 512, 513, 516, 524, 549, 567, 570, 574, 579, 580, 583, 595, 603, 606, 607, 612, 614, 621, 623, 636, 639, 642, 651, 652, 653, 654, 660, 665, 666, 667, 687, 688, 689, 699, 712, 715, 716, 720, 742, 755, 760, 773, 776, 782, 790, 796, 808, 815, 832, 838, 840, 842, 845.

Religion

272. Bernstein, I.C. Sterilization: Social and psychiatric considerations. *Medical Aspects of Human Sexuality* 14(3): 61-62, 1980.

Social and psychiatric considerations for advice and guidance concerning sterilization are discussed. Psychiatric considerations include personality evaluations, contraindications, marital evaluations, and feelings of ambivalence. Social considerations include informed consent, waiting period, religious consultation, coercion and stress, and female sterilization vs. vasectomy. Terminating the reproductive career of a patient should not be considered innocuous even though the procedure is simple. It should be carried out with a complete study of the patient's personality and relationship with the significant other.

273. Bissonette, R. The role of the clergy in community mental health service: A critical assessment. *Psychiatric Quarterly* 51(4):294-299, 1979.

The role of the modern clergy is examined along several dimensions in order to provide a more rational basis for determining their true potential in community mental health services delivery. The clergy has traditionally been a source of counsel for individuals with emotional/mental problems. In addition, they occupy a status open to approach by both acquaintances and strangers. The question of the relationship between caregiver/helpseeker status and disclosure with reference to the clergy will require further research. While role separations might prove problematic, changes in the traditional clerical role might contribute to the clergy's being predisposed to seizing a new identifiable function. The above suggests an expanded role for clergy in the delivery of mental health services. While administrators have evidenced little interest in employing the clergy in such a role, continuing training and consultation programs, together with evaluative research, will provide a base for greater recruitment and utilization of this resource.

274. Brown, P.B. Field interviewing of parish clergy. *Journal of Pastoral Care* 34(2):95-103, 1980.

The process and results of structured field interviewing as a means of gathering data from parish clergy regarding their professional function are presented. In particular, the study concerned incidence of and reaction to suicide among members of parishes of the ministers interviewed. It was found that a mental health chaplain can meaningfully interview pastors provided excessive interviewee anxiety is relieved by skilled and sensitive

questioning within the framework of an objective, structured interview procedure which also facilitates gathering data in a consistent manner. It is suggested that the therapeutic effect of a well-conducted interview upon interviewees may be significant. Field interviewing as a tool is also recommended as useful in discovering opportunities for pastoral consultation.

275. Gill, J.J. Consultations by a priest-psychiatrist. *Psychiatric Annals* 8(4):99-114, 1978.

A wide variety of consultative activities are reviewed from the experience of a Catholic priest with a mastery of medicine and psychiatry. These activities include counseling in educational institutions, religious groups, situations where cultural or political factors are important, and consulting with business people. Two projects for the future are discussed, including the development of an epigenetic theory of the growth of human spirituality and the establishment of a medical, psychiatric, and counseling information center that would be made available to religious superiors, personnel officers, and spiritual growth facilitators. It is concluded that work in areas where psychiatry meets other aspects of life can be interesting, challenging, and rewarding.

See also:

119.

Social Work

276. Bernstein, B.E. Lawyer and social worker as an interdisciplinary team. *Social Casework* 61(7):416-422, 1980.

Interdisciplinary collaboration between the social worker and the lawyer is discussed as a means for effective treatment in areas of premarital and cohabitation counseling, the divorce process, custody, and estate planning for the elderly. Special legal and mental health problems which may arise in each of these areas are reviewed. The scope of such a team is service: when the need arises, the professional colleague is consulted and the team is formed. Important steps that should be taken as the team assembles include obtaining a release from the client permitting information exchange; establishment of rapport among lawyer, social worker, and client; constant communication; resolution of professional conflicts that may arise in the course of collaboration; recognition of the limits of expertise; and the availability of the team for followup services if necessary. Rarely does an individual or family share problems that are purely legal or purely social/emotional; collaboration between the lawyer and the social

worker can provide the expertise needed for best serving the interests of the client in such cases. (abs.)

277. Beruldsen, J. Rural adjustment and the social worker. *Australian Social Work* (North Richmond) 31(2):15-20, 1978.

The possible role of social workers in Australian efforts in rural adjustment counseling is discussed. It has been recommended that counseling and adjustment services available to farmers and rural communities be coordinated, and that the services of social workers be used. Problems facing rural communities include a variety of economic needs, lack of transportation and communication services, and lack of action toward decentralization. It is asserted that social workers can serve these needs by promoting cooperation between agencies and consulting with other professionals who provide services to rural communities.

278. Fritz, A.S. Alternatives to corporal punishment in the school. *Social Work in Education* 1(1):39-52, 1978.

The role of the school social worker in helping to institute alternatives to corporal punishment in the school is discussed. Too often a communication barrier exists between the teacher, who will describe a problem in terms of behavior, and the social worker, who diligently pursues a "problem." The problem/person/situation model is suggested with the social worker as task collaborator. Because of the problem orientation that governs school consultation, social workers will seldom be invited into the classroom on a routine basis. It is concluded that in spite of these difficulties, social workers have an obligation to devise ways to make their services available to more than a few troubled individuals in the school setting.

279. Grossman, L.; Harrell, W.; and Melamed, M. Changing hospital practice and social work staffing. *Social Work* 24(5):411-415, 1979.

Suggestions are made for adapting hospital social worker staffing policy to changes in hospital practices. It is suggested that a situational approach to social work staffing is preferable to a universal formula. Among the changes currently occurring in hospital practice are increases in ambulatory care, changes in hospital missions, equal access of all patients to all types of hospitals, and increased role specialization. In such a changing atmosphere, social workers' professional satisfaction might be enhanced by a role redefinition emphasizing consultation, education, and research. Role redefinition in social work is necessitated by role redefinitions in other health professions that

encroach upon social work roles. An example is given of how an education approach can be used to restructure hospital referral policies.

280. Gutheil, I.A. The problem of resistance in nursing home consultation. *Social Casework* 65(1)40-44, 1984.

A nontraditional approach to social work consultation in a nursing home may pose a threat to established roles and routines. Resistance to such consultations is examined in terms of one home's hidden dynamics. A way in which a consultant can work within the system is proposed.

281. Joseph, M.V., and Conrad, A.P. A parish neighborhood model for social work practice. *Social Casework* 61(7): 423-432, 1980.

The parish neighborhood, a natural ecological structure, is examined as a significant and emerging mediating structure that provides a matrix for provision of social service within the context of agency affiliated programs in the Catholic Church and exploratory descriptive research on those programs. The model outlined is applicable to other natural structures and natural social networks where shared values and resources provide a basis for identification, community building, and service delivery. The organization, funding, extent, and direction of parish-centered social services are delineated. The dominant thrust of services offered in these settings has included individual, family, and group counseling; volunteer activities; and work with the aged. The practice model outlined has the capacity to promote environments supportive to human well-being; through outreach techniques and consultative skills, natural helping networks can be identified, strengthened, and expanded and artificial networks can be developed for meeting a variety of needs in times of economic resource limitations and shifting social values and lifestyles.

282. Kadushin, A., and Buckman, M. Practice of social work consultation: A survey. *Social Work* 23(5):372-379, 1978.

A survey of 483 members of the National Association of Social Workers who had identified consultation as their primary job responsibility is presented. Data were obtained regarding arrangements for and structure of the consultation session, motives for consultation, identification of the consultee and consultee agencies, problems in consultation, types of consultation requested, nature of intervention offered, typical examples of recent consultation, consultants' orientation toward consultation, and their perception of their consultee's orientation. Responses to the questionnaire suggest that although social work consultation can

be identified as a distinctive process, it has yet to achieve a clear and stable image. Responsibility for defining the functions that social work consultation performs and for affirming the help that such activities can offer social work and nonsocial work consultees rests with the limited cadre of social work consultants.

283. Kornblum, H., and Marshall, R.E. A clinical social worker's function as consultant in the neonatal intensive care unit. *Social Work in Health Care* 7(1):57-65, 1981.

Through weekly meetings with a clinical social worker, the nurses in a neonatal ICU gain emotional support and professional growth through exchange of ideas and feelings about death and complex ethical considerations. In the role of consultant/liaison, the clinical social worker heightens the awareness of the neonatologists/administration to the many problems of their staff nurse colleagues.

284. Lerner, D. Consultation on alcoholism in a general hospital. *Health and Social Work* 3(1):103-125, 1978.

A program to provide education and consultation to members of a hospital staff to effect basic changes in their knowledge and attitudes toward alcoholism is described. A social work consultant on alcoholism worked directly in a nonsupervisory position with other social workers to provide special expertise to coordinate the work of the hospital social workers with that of the hospital's alcoholism counselors. The gradual acceptance by line social workers of the idea of alcoholism consultation as helpful and nonthreatening is described. Conflicts between hospital social workers and alcoholism counselors were lessened by encouraging team enterprise. A formal 8-week education phase of the consultation service dealt with casework techniques and the social workers' feelings of hopelessness in their attempts to cope with debilitated alcoholics. Sessions focused on medical aspects of alcoholism, Alcoholics Anonymous, and specialized treatment facilities. The social work consultant on alcoholism was made a part-time position in which case consultations were limited to special problems. Clear indications of the program's success include improved treatment of alcoholic patients and a more positive attitude by the hospital staff on the treatability of alcoholics.

285. Mathew, G. Consultation in social work practice. *Indian Journal of Social Work* 43(4):333-350, 1983.

Discusses the concepts and theories of consultation; presents the content and dimensions of social work consultation as it is practiced in India; and discusses the applicability of a conceptual framework, developed through a review of the literature, to the

Indian situation. Two types of social work consultants operate in India: (1) those who are designated as consultants, and (2) those who offer consultation along with other services, but without the designation of consultant. The author's experiences with social welfare organizations in offering consultative services are presented.

286. Munson, C.E. Interaction of staff and residents in adolescent group homes. *Free Inquiry in Creative Sociology* 7(2):174-177, 1979.

A report of the results of ongoing social work consultation activity provided to a small group home with paraprofessional staff members and 14 residents who are severely acting-out adolescents is presented. Role theory is used to define the roles of the consultant, staff, and residents in the consultation process. The theory focuses on the staff as a small group and how the dynamics of staff interaction are reflected in resident group behavior. The staff group process is analyzed through exploration of (1) achieving honest and clear communication; (2) acceptance and use of authority; (3) staff anxiety and threatening situations; and (4) development of appropriate levels of genuineness and self-awareness. Consultant functions in this process are identified and explained, and specific examples of therapeutic intervention strategies are covered. (abs.)

287. Parr, G., and Altstein, H. Social work in a Catholic school system: A study. *Social Work in Education* 1(4):5-20, 1979.

The features of a Catholic school social work program in eight Catholic elementary schools in Baltimore are described in the following areas: (1) demographic characteristics of clients, (2) types of problems presented, (3) referral sources, and (4) kinds of services offered. Data were derived from a representative sample of 45 cases from the 128 clients served between September and March 1975. Demographic data obtained on clients revealed that a typical student in the program would be a white male between 6 and 9 years of age. Typical parents would be a white couple between the ages of 25 and 35, having a high school education and three children. Three categories of problems were established: (1) emotional/behavioral, (2) academic, and (3) domestic. The primary source of referral was teachers, although parents accounted for about 30 percent of referrals. Services offered included (1) consultation with teachers, (2) conferences with principals, (3) classroom observation, (4) referral for psychological testing, and (5) interviews with parents and families. Implications for practice are discussed in terms of social case worker roles.

288. Rosenberg, E.B., and Nitzberg, H. The clinical social worker becomes a consultant. *Social Work in Health Care* 5(3):305-312, 1980.

This paper deals with the consultative function of the social worker in a university hospital system. Although clinical social work in many psychiatric settings is narrowly confined to diagnosis and treatment, role expansion in the function of consultation is possible. While clinical skills are important for the evolving consultant, these need to be constrained as consultation takes place in a coordinate relationship. The developmental experience of one of the authors in a day care center is cited.

289. Sefcik, T.R., and Ormsby, N.J. Establishing a rural child abuse/neglect treatment program. *Child Welfare* 57(3): 187-195, 1978.

The development and problems of Project Children, a rural child abuse/neglect program serving a five-county area in south central Indiana, are described. After training of a child protective service staff and initiation of a consultation service, a multi-disciplinary team approach to child abuse was initiated which included a hospital protocol for reporting suspected child abuse cases to the child protection team of each county. The lack of available staff, the lack of time to devote to the abusive family, and the threat imposed by the Department of Public Welfare in regard to removal of an abused child all indicated the need for an alternative method of servicing the abusive parent. Therefore, volunteers were recruited to meet the needs of abusing families. In addition, the community education and preventive aspects of the program are explained.

290. Stewart, M., and Lazere, A. A model for cooperation between social workers. *Health and Social Work* 3(3): 190-194, 1978.

A case history that provided a model for cooperation between a nursing home and a community mental health center and provided extended roles for the social workers involved is presented. The factor precipitating the cooperation between social workers was the emotional illness of a 27-year-old man, the victim of an automobile accident. Sessions were held at the nursing home, allowing the mental health center worker immediate consultation with the nursing home staff. It is concluded that this case provided the impetus for opening cooperative channels for service between a nursing home and a community mental health center and broadened the scope of responsibilities and practices.

291. Stork, H., and Foucher, A. Psychopathology of the young child and prospects for prevention. *Psychiatrie de l'Enfant* 22(1):127-236, 1979.

Living conditions of young children in a Paris suburb and their psychopathology were studied by a multidisciplinary team. Clinical observations illustrate the psychopathology encountered among children of preschool age and the proposed therapeutic measures. The need for early diagnosis is emphasized. This type of work is evaluated after 9 years in cooperation with families and schools. Good coordination of social services resulted in an increase of consultations concerning children under 5 years of age from 43 to 56 percent between 1972 and 1977. The percentage increased during the same period from 33 to 47 percent with regard to children born in sociocultural environments which are particularly underprivileged and considered generally inaccessible for this type of approach. (abs.)

292. Unger, J.M. Consultation: Capitalizing on hospital social work resources. *Social Work in Health Care* 4(1):31-41, 1978.

A social work consultation program, developed in response to concern about the steady increase in the transfer of patients to nursing homes and the need for social work coverage of local nursing and shelter care homes, is described. Issues and practice in consultation are examined, particularly as they relate to services in health care facilities. Notes on the structure for establishing a consultation program in a health care facility are presented. (abs.)

293. Webb, N.B. Crisis consultation: Preventive implications. *Social Casework* 62(8):465-471, 1981.

The close relationship between crisis intervention and prevention is discussed in the context of social work consultation with preschool and senior citizen centers. The location of service in community settings provides opportunities to reach nonclient populations facing either anticipated or unanticipated crises. Prevention is often a serendipitous byproduct of effective social work practice, although it is not usually earmarked as a major practice goal, nor is it frequently identified as an important outcome of service. This model represents a blending of mental health consultation and crisis intervention techniques, with a flexible, time-limited application of direct service to maximize the preventive potentials of social work practice. (abs.)

See also:

315, 321, 324, 354, 357, 387, 410, 425, 439, 447, 455, 669, 692, 698, 741, 753, 772, 784, 833, 851.

Additional Mental Health Consultants

294. Dale, S. School mental health programs: A challenge to the health professional. *Journal of School Health* 48(9): 526-529, 1978.

A theoretical framework for the promotion of mental health in the schools is presented. Examples of specific health activities relating to the framework as well as the barriers to be overcome in order to promote mental health are described. Counseling, consultation, and communication activities to promote mental health can be readily provided by school health personnel. Barriers to the development and implementation of a mental health program include problems in staffing and communication as well as a continued illness orientation of the health professional. (abs.)

295. Ecklund, L.A. The role of a regional treatment center in a model mental health delivery system. *Hospital and Community Psychiatry* 29(6):379-383, 1978.

The evolution of the Mendota Mental Health Institute in Madison, Wisconsin, from a traditional state hospital to a regional mental health center in response to the growth of the community mental health movement is described. The Institute offers specialized treatment services for those who cannot be cared for in community programs, education and consultation services, and research into treatment methods. These are seen as backup services which could not be provided by a community mental health center. A mental health delivery system with primary, secondary, and tertiary levels of care (regional centers similar to Mendota at the third level), and a fourth level providing protective care, are proposed. (abs.)

296. Gerber, B.M. Statewide planning of coordinated mental health services for deaf persons. *Mental Health in Deafness Experimental Issue* No. 2:37-42, 1978.

Efforts in Massachusetts toward a statewide coordinated approach to the development of mental health services for deaf persons are described. Emphasis is placed on the functions of the Director of Mental Health Services for Deaf Persons, in the Department of Mental Health, who is responsible for program planning and development, consultation, interagency coordination of services,

and advocacy. The origins of this position, its functions, accomplishments, shortcomings, and future tasks are discussed, as well as the significance of statewide coordination of mental health services for deaf persons. (abs.)

297. Gilfoyle, E.M., and Hays, C. Occupational therapy roles and functions in the education of the school-based handicapped student. *American Journal of Occupational Therapy* 33(9):565-576, 1979.

In a study oriented toward manpower training needs, current roles and functions of the occupational therapist serving school-based handicapped pupils were identified through data analysis of surveys conducted in 1978. Major roles identified were evaluating and screening pupils with a variety of problems in order to specify goals for occupational therapy interventions; participating in educational program planning to coordinate occupational therapy goals with total educational programs; implementing appropriate interventions to enhance maximum functioning and to facilitate the pupil's learning and development; managing and supervising the school-based occupational therapy program; and consulting with school personnel and parents. Specific activities and services relevant to these major roles are also delineated. (abs.)

298. Hearing-impaired patients: Innovative program in Minneapolis. *Today in Psychiatry* 4(9):1-9, 1978.

The inpatient and outpatient mental health care, home visits, and other services provided by the center for Mental Health and Hearing Impaired (MHHI) in St. Paul, Minnesota, are described. MHHI services focus on hearing-impaired persons who require only short-term psychiatric hospitalization or none at all. Emphasis is placed on education, and sign language is favored over lip reading or the teaching of speech skills. The center also offers consultation and referral services, and provides interpreters to other hospital clinics and departments when they need assistance in dealing with deaf patients. The need for similar and more extensive services to reach the 13.5 million hearing-impaired persons in the United States is emphasized.

299. Mawson, C.D. Women's centers: A critical appraisal and a case study. *Personnel and Guidance Journal* 58(1):61-65, 1979.

A critical overview of women's centers, which have arisen in response to the life planning and informational service needs of women in transition, is presented, and a financially self-supporting women's center in New Orleans is described. Two types of programs, in terms of funding sources, are delineated

together with their inherent problems. Shoe string programs tend to have high staff and client turnover, may compete with other agencies for funds and limited extramural support, and tend to channel women into low paid sex-role stereotypic jobs. Well subsidized programs are subject to funding vagaries and may be hampered by the vested interests and bureaucracy of the supporting institution. The New Orleans women's center attempted to overcome these problems. The center is designed to aid women in transition in building self-esteem, establishing new patterns of constructive action, considering options, defining goals, and facilitating achievement of goals. In view of sexist overtones of traditional counseling, an educational counseling model was implemented which emphasizes the client as problem solver and learner of new skills. Center activities include counseling, information, referral, seminars and workshops, research, evaluation, and consultation.

300. Nadeau, J.S.; Fagan, S.H.; and Schuntermann, P. Child custody: The adversarial process as a vehicle for clinical services. *Children Today* 7(6):14-35, 1978.

A program that has been conducting evaluations of children and families involved in child custody cases in the court system for 4 years is evaluated. The program, offered by a private child guidance clinic, consists of a team composed of a child clinician, an adult clinician, and a lawyer. The multidisciplinary approach includes individual sessions, family sessions, psychological testing, home and school visits, and consultations with other agencies. A report is then sent to the court with definitive recommendations regarding the best interest of the child or children involved. To date all of the recommendations regarding custody have been heeded by the courts. A team approach, oriented through the legal system and working independently of client or patient, can greatly enhance the ability of the judiciary to make informed judgments. It is concluded that the program provides an opportunity for legal and mental health professionals to collaborate to protect and advocate the best interest of the child.

301. National Institute of Mental Health, Center for Studies of Child and Family Mental Health. Parents as cotherapists with autistic children. *Parent-Child Program Series, Report No. 3*. DHEW Pub. No. (ADM)78-655, Washington, DC: GPO, 1978.

A program developed at the Child Research Project at the University of North Carolina that enables parents to work with their autistic and communication-handicapped children is described. In the North Carolina program, considerable time is spent determining a child's particular problems and therapeutic

needs before a treatment program is instituted. The Psycho-educational Profile is used to explore many aspects of a child's functional capabilities. Typically, a family is expected to come to the center weekly to attend 45-minute therapy sessions. The parents observe the therapy through a one-way screen with another therapist who provides consultation. The child's sessions with the therapists are reinforced through regular activities carried out daily at home with the parents. Parent group meetings provide an opportunity for parents to share experiences and learn more about childhood psychosis and its management. Program staffing, special facilities and resources, and the impact of the program are discussed.

302. Nielsen, E., and Kaslow, F. *American Journal of Family Therapy* 8(4):35-42, 1980.

Addresses the issue of the use of consultants by experienced family therapists. The need for consultation under different circumstances is discussed and a review of models currently being used is presented. Emphasis is placed on preparing clients for the consultation, providing background information to and preparing with the consultant for the session(s), and transferring "power" to the consultant and back again to the primary therapist.

303. Paul, R.E. Attorney serves MHC legal needs. *Innovations* 7(1):37-38, 1980.

The services and performance of a legal advocacy unit created to intervene in legal matters on behalf of the professional staff of community mental health centers (CMHCs) are examined. Basically, unit staff see themselves as mediators between the CMHC and the juvenile justice, education, and child welfare systems. The lawyers can interpret laws, provide necessary information in the courtroom, and see that timetables are carried out. Two examples of cases in which intervention by a lawyer from the advocacy unit helped reach a solution are presented. In some centers lawyers are involved in the consultation and education component of services, speaking before community groups about such issues as children's right to education and rights of mental patients. Another task a CMHC attorney may perform is testifying before legislative and regulatory hearings on proposed laws and regulations that will have a direct impact on human service agencies.

304. Peterson, C.L.; Wirth, B.A.; and Wolkon, G.H. Paraprofessional role in a mental health continuing care program. *Health and Social Work* 4(3):64-81, 1979.

A program in which paraprofessionals provide continuing care services to patients before and after discharge from the Psychiatric Hospital of Los Angeles County, University of Southern California Medical Center is described. Paraprofessional caseworkers, as members of multidisciplinary teams, are involved in the following duties: supportive interventions with patients; collection of forms completed by staff documenting specific arrangements for continuing psychiatric treatment, resocialization, and vocational plans; consultation with patients, families, and other members about available community resources and referral procedures; direct services to patients for concrete residential, financial, and social needs; collaboration with families, friends, and community resources in continuing care planning and followup contacts to reinforce treatment recommendations and handle difficulties of community adjustment. Paraprofessionals in the Continuing Care Program have earned bachelor's degrees in the social sciences. Data from 100 patients indicate that paraprofessional caseworkers effectively managed 85 percent of the patients' post-discharge problems without needing directly to involve their professional teammates.

305. Rybal'skiy, M.I. Tasks and certain specific features of managing an alcoholic treatment clinic. *Zdravookhraneniye Rossiyskoy Federatsii (Moskva)* 6:38-41, 1979.

The component parts of a comprehensive clinical treatment program for alcoholics are listed and discussed. The basic tasks involved in such treatment fully correspond to the general principles guiding Soviet mental health treatment. Among these tasks are active search for persons suffering from alcoholism; thorough study of the work and living situations of the patient; formation of therapeutic teams corresponding to the patient's stage of alcoholism; use of social or administrative measures to start the patient in his course of treatment; organization of individual work readaptation and social rehabilitation programs; preparation of materials for sessions of local commissions against alcohol abuse; and consultations with general hospitals and non-medical institutions on cooperation in treatment and prevention problems. In practice, episodic and systematic variants of alcoholism are distinguished. The symptoms of the onset of the earliest stage of the disease, its most curable period, are described. The problem of length of treatment is discussed. It is emphasized that practical difficulties tend to arise not so much in

the choice of a therapeutic tactic, as in ensuring that the patient makes regular visits to the treatment center.

306. Small, R., and Goldhamer, P. The professional role within a self-help model: A "widow-to-widow" project. *Journal of Jewish Communal Service* 56(2):176-180, 1980.

The function of professionals within a self-help group is examined using a widow-to-widow program as an example. Project activities designed to help newly widowed women get ongoing emotional support from peers who have already resolved their grief, as well as to provide practical input concerning economic, social, education, and career issues, are described. The self-help model is defined and current literature is examined with regard to guidelines for professional intervention. It is concluded that the self-help model in conjunction with professional consultation may constitute the most effective means of helping a widow make the transition from a view of herself in a couple to a view of herself as an adult woman without a partner.

See also:

44, 52, 314, 367, 374, 381, 398, 407.

Consultees by Consultative Settings

Correctional and Legal Settings

307. American Association of Correctional Psychologists. Standards for psychology services in adult jails and prisons. *Criminal Justice and Behavior* 7(1):81-127, 1980.

The standards of the American Association of Correctional Psychologists for psychological services in adult jails and prisons are presented. In the preamble, it is noted that no presumption of emotional disturbance among persons in the criminal justice system is implied, but that every correctional facility must adequately serve the mental health needs of its inmate population. The following topics are discussed: administration, staffing and professional development, ethical/legal issues, access to services, screening/evaluation, inmate treatment and management, consultation, inservice training, volunteers, and research and records.

308. Anderten, P.; Staulcup, V.; and Grisso, T. On being ethical in legal places. *Professional Psychology* 11(5):764-773, 1980.

The ethical problems confronting psychologists who participate as expert witnesses in the legal process are described. The origins of such problems are examined in light of important differences in purposes between psychological practice and legal process, particularly as they relate to issues of advocacy and objectivity. Special attention is given to the problem of objectivity in the courtroom, and the client's psychological welfare. Suggestions for maintaining ethical practice in the role of expert witness are provided including an understanding of the legal process and problems inherent in psychological testimony, an examination of one's own needs and motives in appearing as an expert witness, consultation and peer review of assessment data, and a collaborative relationship with the attorney and the court. (abs.)

309. Burkhart, B.R., and King, G.D. Blind men and elephants: A case study of consultation with police. *Journal of Community Psychology* 9(2):133-139, 1981.

Presents a case study of a consultative intervention with an internally conflicted police department. The multidimensional factors sustaining the difficulties are illustrated through the consultant-trainee intervention model. A pre-postevaluation supported the effectiveness of the intervention.

310. Derdeyn, A.P. Child custody: A reflection on cultural change. *Journal of Clinical Child Psychology* 7(3): 169-173, 1978.

Issues of child custody in divorce are examined. The recent interest in and advancement of women's equal rights has worked to women's disadvantage with regard to custody. Fathers are now approaching an equal right to custody and mothers are being held equally responsible for child support. As a result of these changes, courts are no longer able to rely on traditional formulas and are being forced to look closely at issues of parenting and other aspects of child care. The greater equality of parents offers new opportunities for courts to consider children's needs, and, in addition, children's needs per se are being accorded increasing attention in terms of their rights to education and to limitations on relitigation of custody decrees. The need for clinically competent consultants with a good understanding of the basic legal issues is on the increase. It behooves professionals in the mental health field to prepare themselves to carry out the difficult and important task of child custody consultation. (abs.)

311. de Swaan, C. GGZ-portrait: Bart de Smit, prison psychiatrist. *Maanblad voor de Geestelijke Volksgezondheid* (Amsterdam) 33(7-8):503-523, 1978.

A portrait sketch of a prison psychiatrist, one of a series of interviews with workers in the mental health care Geestelijke Gezondheidszorg (GGZ) is presented. An attempt is made to illustrate the daily experiences of specialists in the field of psychosocial assistance. A representative in a key position at the crossroads of criminal law and mental health care was interviewed. Consultation, the job of a district psychiatrist, the prison environment, staff meetings, roles and limits of his powers, the solving of prison conflicts, and the punishment processes are discussed.

312. Feldman, H.S. Psychiatric functions in a forensic unit. *Journal of the Medical Society of New Jersey* 75(10): 664-666, 1978.

A forensic psychiatric unit at the Essex County jail in New Jersey is discussed. The unit was established by the New Jersey Medical School for psychiatric examinations of criminal offenders. The functions of the unit include determination of competency, commitments to hospitals, inpatient psychiatric service, training of residents, psychiatric consultations, educational meetings, and family consultations. A forensic psychiatric unit is recommended as an integral part of departments of psychiatry because the functions of such a unit serve the community and the teaching programs of the medical school.

313. Floyd, J. The community readjustment program. *International Journal of Offender Therapy and Comparative Criminology* 23(2):147-158, 1979.

The community readjustment program, a mental health service program for excriminal offenders, is described. The program's primary goal is to provide a free outpatient psychological service for exoffenders and their families on a no-waiting-list basis, and to provide case consultation for parole and probation officers upon request. The program emphasizes reality confrontation and encourages exoffenders to take responsibility for their actions in meeting life's difficulties. Topics discussed include the low self-esteem of exoffenders, a therapeutic group for wives and girlfriends of exoffenders, effects of the program on recidivism, and the need for flexibility of therapeutic approach.

314. Heller, J.R., and Derdeyn, A.P. Child custody consultation in abuse and neglect, a practical guide. *Child Psychiatry and Human Development* 9(3):171-179, 1979.

Mental health professionals are being asked with increasing frequency to consult to the courts regarding custody in cases of suspected abuse and neglect. This paper provides practical guidelines for evaluation of these families in order to maximize the effectiveness of consultation and minimize common pitfalls usually encountered with such evaluations. The authors offer suggestions for structuring the evaluation, dealing with family resistance, writing the report, and testifying in court. It is hoped that with such practical guidelines, other mental health professionals will be willing to attempt such consultations and will be able to structure them in such a way that they can be carried out efficiently and effectively, benefiting not only the courts, but the children and their families as well.

315. Hoorwitz, A.N. The visitation dilemma in court consultation. *Social Case Work* 64(4):231-237, 1983.

Discusses pro and con arguments on the question of whether it is in the child's best interest for the court to force visitation with the noncustodial parent or for the court to vest the custodian with the power to determine conditions of visitation and even deny it. Research on this issue is reviewed, and strategies for dealing with it are suggested. Topics discussed include stresses of visitation. The role of the consultant in mediating visitation disputes is discussed.

316. Hurwitz, E.; Menacker, J.; and Weldon, W.W. Consultation in a prison environment. *Journal of Offender Counseling, Services and Rehabilitation* 4(1):19-31, 1979.

A consultation program developed for the PACE Institute, a private educational service at the Cook County, Illinois, jail, is described. Consultation is aimed at establishing a positive atmosphere which is conducive to development of positive self-concepts and attendant personal and interpersonal skills. An existing program format, the Washington Lift program, was successfully applied to meet this objective. (abs.)

317. Lieber, A.L. Consultation with the police: The psychiatrist as organizational change agent. *Comprehensive Psychiatry* 19(1):57-64, 1978.

The role of a psychiatric consultant to the City of Miami Police Department in Florida is described, and his interaction with and impact upon the police department in promoting occupational

mental health are discussed. Issues which were addressed initially were racial strife, police role concepts, and organizational changes which deemphasized crisis orientation and emphasized a problemsolving approach to make the department more effective. The functions of the psychiatric consultant were (1) to establish a trust and rapport between himself and department key personnel; (2) to analyze the organizational personnel relationship and modes of communication; (3) to establish a field training instructor program utilizing highly motivated police officers as trainers of probationary officers in a program designed to promote a "good guy" role concept; and (4) to establish a senior staff management seminar which would address goals, role conflicts, and the opening of lines of communication. Guidelines to be followed by psychiatrists given the opportunity to consult police departments are offered.

318. McLachlan, D.G. Psychiatry and the law. Australian and New Zealand Journal of Criminology (Sydney) 11(1):43-53, 1978.

In a paper presented to the Medico-Legal Society of Wellington, New Zealand, May 1976, the role of the lawyer and the psychiatrist in the courtroom, the specific responsibilities of each in giving and extracting testimony and the uses of psychiatry in serving the law are discussed. Because of the wide divergence in training, lawyers and psychiatrists are often suspicious of each other. This can be alleviated if psychiatrists testify or consult in laymen's terms and realize they are fallible at times and if lawyers use courtesy and respect in their dealing with the psychiatrist. On the other hand, lawyers should understand that the difference between psychology and psychiatry does not take into account the complexity and indivisibility of the mind: emotions and drives are closely linked to the function of reason and human motivation and is compounded by many factors. The operations of the law to which a psychiatrist can contribute include helping to establish a person's sanity or state of mind before, during, or after a crime; determining testamentary capacity or the ability to make a valid will; and judgments about clients, e.g., fitness to possess a firearm. It is emphasized that there is no sharp dividing line between sanity and insanity.

319. Moore, J. Community mental health consultation in the police court. Perspectives in Psychiatric Care 18(5):204-209, 1980.

The author describes her work as a mental health consultant with the Albany Police Court. The consultative process is discussed in four phases: point of entry, problem solving, implementation, and evaluation.

320. Mortillaro, L.F. The use of psychological services in a juvenile court setting. *Juvenile and Family Court Journal* 29(2):7-12, 1978.

Model role and organization of psychological services in a juvenile court setting are proposed. Therapeutic services should include, though not be limited to (1) individual, group, family, and crisis intervention therapy; (2) prescriptive therapeutic program development in response to court requests; (3) recommendation of appropriate system- and community-based behavior modification programs; (4) an information clearing house; (5) community-system program liaison and coordination; and (6) supervision and consultation for paraprofessional service providers. In addition, services should provide a data base of research and program evaluation to aid in treatment and organizational planning and decisionmaking. Assessment/diagnostic services should incorporate observation, delineation of etiology, classification, prognosis, and control-modification or treatment plan. Juvenile court psychological services staff can serve a consultative role to the courts and to other system- and community-based services and personnel. The psychologist can serve in a training capacity. An in-house organization with direct access to all levels of the system, especially the administration and the judiciary, is recommended.

321. Mukherjee, S.C. Jail counseling project. *Innovations* 5(1):38, 1978.

A jail counseling program in Xenia, Ohio, which provided cooperation between law enforcement and mental health personnel, is described. The Green County Guidance Center, Inc., piloted a 5-month jail counseling project. The goals of the project were to provide counseling services to prisoners experiencing emotional stress while incarcerated and to consult with the jail staff concerning ways of managing prisoners who were experiencing emotional stress. A psychiatric social worker visited the county jail on a regular basis, screened the inmates, and contacted a staff person from the guidance center. The counseling sessions were held at the jail. The success of the program is measured by the fact that the project has now become a part of the center's ongoing services.

322. Petrich, J. Psychiatric treatment for offenders. *Bulletin of the American Academy of Psychiatry and the Law* 7(2):157-165, 1979.

The elements of a comprehensive psychiatric treatment program for inmates in jails and prisons are outlined. Standards for such a

program were developed by an American Medical Association task force. Program priorities include recognition and treatment of the severely mentally ill (psychotic, demented, psychotically depressed, or suicidal inmates), recognition and treatment of the less severely ill (anxious and nonpsychotically depressed inmates), and psychiatric consultation for the broader institutional human service programs. Guidelines for training of psychiatric staff as well as for conformity to applicable State and Federal laws, are included. Problems in funding, interagency cooperation, and assignment of priorities are discussed.

323. Soskis, D.A. Behavioral scientists and law enforcement personnel: Working together on the problem of terrorism. *Behavioral Sciences and the Law* 1(2):47-58, 1983.

Behavioral scientists work with law enforcement personnel on the problem of terrorism in three general contexts: clinical help for victims, training and consultation for hostage negotiation, and profiling and institutional consultation. In a study of 115 senior police officers working in the area of terrorism, 22 valued psychological counseling for crime victims within a broad framework of financial and criminal justice services. When describing a past personal victim experience, they valued direct physical action in their own coping, but expressions of sympathy and reassurance when provided by others. Problems encountered by behavioral scientists working in this area have usually involved difficulties in maintaining an effective consultant role, overidentification with the law enforcement identity, or inappropriate media statements.

324. Steen, R. Child abuse units in law enforcement: Dateline: Baltimore County, MD. *Police Chief* 45(5):38-39, 1978.

The work of the child abuse unit of the Baltimore County Police Department is described. One of the first of its kind for investigating child abuse, the specialized unit's two basic functions are identified as (1) collecting all information necessary in child abuse cases for possible prosecution; and (2) making a determination, through consultation with the Protective Services Section of the Department of Social Services, as to whether prosecution or provision of professional counseling would be more beneficial to the child and the family unit. Criteria for making such decisions are described. Other types of coordination between the child abuse police unit and other social service agencies are also discussed.

325. Suarez, J.M.; Weston, N.I.; and Harstein, N.B. Mental health interventions in divorce proceedings. *American Journal of Orthopsychiatry* 48(2):273-282, 1978.

The different types of mental health intervention available during the divorce process are enumerated. In addition to the traditional diagnostic and evaluative services typically requested by the legal system, preventive and therapeutic programs can be developed. Implementation of a program by the UCLA Section on Legal Psychiatry is described. The program has prepared mental health professionals to function more effectively within the legal system and also increased the awareness of judges and attorneys of mental health issues, psychological factors underlying litigation, and the appropriate and effective use of mental health consultation. (abs.)

326. Wittenbeck, S., and Szewczyk, H. The role of forensic psychiatrists in the establishment of criminal guilt. *Psychiatrie, Neurologie und Medizinische Psychologie* 31(2):101-107, 1979.

Issues raised during consultations between psychiatrists in the German Democratic Republic and members of the GDR Supreme Court are discussed. Questions arising in connection with expert opinions on responsibility and guilt; concerning the offender's personality, motives, type and extent of guilt, possible exclusion of guilt, as well as urges of passion beyond the limits of legal exposition; and exceptional objective and subjective circumstances of some criminal actions are explored. Examples of legal cases to illustrate some of these considerations are presented. It is suggested that in the interest of reducing criminality, the judicial system should consider the prognosis and, as far as is possible, suggest suitable measures. (abs.)

See also:

50, 158, 163, 227, 233, 256, 300, 468, 520, 817, 840.

Cross-cultural and International Settings

327. Pergamenter, R. Crisis intervention with child-care personnel (metaplot) in Israeli border kibbutz. Series in *Clinical and Community Psychology: Stress and Anxiety*, 8:355-360, 1982.

See also:

761.

Educational Settings

328. Alpert, J.L. Consultation and the analysis of school faculty meetings. *Professional Psychology* 10(5): 703-707, 1979.

The use by school consultants of faculty meetings for diagnostic, training, and evaluation purposes is discussed. A first visit to a faculty meeting at an innercity Catholic elementary school is described, and the implications of this meeting for consultation activities are discussed. The social psychological approach presented could also be applied to staff meetings at institutions other than schools. (abs.)

329. Alpert, J., and Rosenfield, S. Consultation and the introduction of social problem-solving groups in schools. *Personnel and Guidance Journal* 60(1):37-41, 1981.

A social problem-solving program for withdrawn and hyperactive children relevant to the school context was developed and implemented in a daycare center, a nursery school, a Catholic elementary school, and a Catholic high school. Described are the background of the consultants, teacher involvement in program development, and implementation in each facility. It is concluded that resistance to school consultation was alleviated by teacher involvement in program development, the very targets (i.e., hyperactive/withdrawn children) of the program since teachers consider them to be major problems, program flexibility, and school-wide participation.

330. Anbeek, M., and Driessen, B. Amsterdam school physicians in high school education. *Maandblad voor de Geestelijke Volksgezondheid (Amsterdam)* 33(5):362-367, 1978.

The function of the school doctor as a psychosocial advisor in the high school is discussed. The type of doctor (medically or psychosocially oriented) and the type of student (lower vocational and secondary education) are determining factors in this function. The cooperation between the school and the school doctors is examined. The school doctor's work, consisting of prevention, consultation, and referral, as well as student populations are discussed. It is emphasized that the school doctor is only one example of assistance available to the adolescent within the second degree assistance circuit.

331. Browne, J.A. An approach to mental health consultation in the schools: Enhancing children's mental health. *Canada's Mental Health* 27(3):7-9, 1979.

A program in group mental health consultation with first grade teachers is described. The purpose of the consultation was to help the teachers gain a better understanding of children's behavioral problems and to develop skills in managing these problems more effectively. The basic assumptions underlying the intervention were (1) the importance of peer acceptance; (2) the importance of the facilitative relationship between the teacher and the children; and (3) the recognition that first grade children can participate in group processes. The consultant provided a model for the teacher in her role in conducting meetings with the children and in utilizing a specific problem-solving approach. Experience with this approach indicates that primary school children can successfully engage in problem-solving meetings focusing on class problems, attitudes, feelings, and relationship difficulties.

332. Chandler, L.A. Consultative services in the schools: A model. *Journal of School Psychology* 18(4):399-402, 1980.

A model Child Evaluation Center was established in a regular public school to demonstrate alternative methods for providing psychoeducational services. In addition to its service/demonstration function, the Center functioned as a psychoeducational field training clinic for the training of school psychologists. The Center was successful in encouraging teachers to utilize consultative services and, in the process, reducing the number of referrals for formal psychological evaluation.

333. Cohen, A.R., and Gadon, H. Changing the management culture in a public school system. *Journal of Applied Behavioral Science* 14(1):61-79, 1978.

The creation of a new management system for a public school system, with different decisionmaking processes, greater administrator involvement, and increased commitment to the entire system, is described. The intervention was based on an action/research model including preliminary diagnosis, collection of data from key people, feedback, identification of issues and problems, formation of action teams, generation and proposal of intervention solutions, determination of courses of action, implementation, and evaluation. Supporting consultation and workshops facilitated the process. On the basis of the experience, propositions covering conditions for behavioral change, consultant-client relations, and workshops are presented for application to and testing in other systems. (abs.)

334. Comer, J.P.; Schraft, C.M.; and Sparrow, S.S. "A Social Skills Curriculum for Inner City Children." Research report, NIMH Grant R01-MH-27561. Unpublished paper, 1979.

A field test of the Social Skills Curriculum Model, which was designed to improve the social climate, level of parent participation, and academic achievement in innercity elementary schools, is presented. The field test school was Brennan-Rogers, which is located in a low-income, black, New Haven, Connecticut, community. At Brennan-Rogers, resources were utilized to stabilize the school governance body, to develop broadly based parent-staff-student activities, to continue the parent participation program, and to expand social skills teaching units into most classrooms. Consultation and resources related to mainstreaming children with learning disabilities were provided in conjunction with a mainstreaming program by the New Haven Public Schools. The first year of the kindergarten enrichment program at Brennan-Rogers was conducted. The details of the evaluation, which was conducted to assess the impact of the project along six dimensions (school climate, student attitudes, academic achievement, impact on staff, impact on parents, and integration of social skills teaching units) are presented.

335. Cramer, B.; Manzano, J.; Palacio-Espasa, F.; and Torrado-Da Silva, M. Prevention programs in a child psychiatric service for preschool children. *Acta Paedopsychiatrica (Basel)* 43(2/3):85-100, 1978.

The opportunity for developing prevention theories and programs and applying them at the preschool age is discussed in the context of services provided at the Geneva (Switzerland) Child Guidance Center. Here, primary prevention is practiced by promoting mental health through intervention by community nurses, kindergarten teachers, and pediatricians. High-risk children (those with psychotic mothers) are followed and crisis intervention is applied. Secondary prevention is practiced by teaching early diagnosis to paramedical groups. Cooperation with community nurses who have a large preventive impact is important. The psychiatrist intervenes at several levels and also can be used by nurses as a consultant for difficult cases. In Balint-type groups, discussions center around problems of professional identity, competition with doctors, and anxiety provoked by the confrontation with maternal psychopathology. Several tables indicate the types of cases seen in consultation, the types of intervention indicated, and the number of hours spent by psychiatrists in this program. The program demonstrates clearly the importance of the preventive impact of community nurses for the preschool age child. (abs.)

336. Diandriole, E.T. Developing a program for crisis intervention. *Journal of the American College Health Association* 26(5):280-281, 1978.

At the Fifty-Fifth Annual Meeting of the American College Health Association, held in Philadelphia on April 20, 1977, a paper was presented before the Section on Junior/Community Colleges explaining a method developed at County College of Morris, New Jersey, for handling psychiatric emergencies at small colleges that do not always have a physician readily available. The use of an emergency phone number and coordination between the campus security force and the counseling center are discussed. It is noted that the first step in handling an emergency is to identify the person in trouble and the second is to establish communication with the person; several methods are suggested. It is recommended that only those persons officially assisting in the emergency should be allowed in the vicinity of the patient. Consultation is suggested to determine the seriousness of the situation and whether first aid should be administered. It is recommended that an evaluation team determine the course of action in dealing with psychiatric emergencies.

337. Dixon, J.W., and Saudargas, R.A. Toilet training, cueing, praise, and self-cleaning in the treatment of classroom encopresis: A case study. *Journal of School Psychology* 18(2):135-140, 1980.

A study was designed to ameliorate encopresis in a 6-year-old male child in the school setting. The procedure consisted of toilet training, cueing, praise, and self-cleaning. Prior to intervention, encopresis was a daily event at home and school. The intervention was successful in reducing the soiling to near zero at school, with no reported changes at home. Implications discussed for school psychologists are (1) handling the intervention through a consultation model; (2) using the simplest approach before attempting more powerful procedures; and (3) attempting treatment in spite of the fact that other treatment attempts at home had been unsuccessful. (abs.)

338. Fedner, M.L.; Biacchi, A.J.; and Duffey, J.B. Priorities of special education teachers regarding consultative strategies. *Psychological Reports* 44(3, Part 2):1181-1182, 1979.

Special education teachers were surveyed to determine their views on school consultative services. The teachers were asked to rank five consultative strategies employed by psychologists. The degree of agreement among the 58 teachers was statistically significant; thus, the rankings were used as an index of the teachers'

priorities. The five strategies were those which emphasize assisting the child and the teacher. The teachers clearly ranked the strategies relating to the child higher. It is suggested that a consultant may speculate that a special educator expects the consultant, at least initially, to deal with the child's difficulties. This would preclude interventions in which the teacher is the first and major focus of the consultant's efforts. Such a generalization supports self-perception and attribution theory. (abs.)

339. Fleming, D.C., and Fleming, E.R. Consultation with multidisciplinary teams: A program of development and improvement of team functioning. *Journal of School Psychology* 21(4):367-376, 1983.

Describes a program designed to assist multidisciplinary teams engaged in screening and eligibility determination to assess their own functioning and set specific goals to improve their case-handling procedures. The program was implemented in four elementary schools and one secondary school of a large suburban school district. Preliminary data are provided on the usefulness of the program in assisting multidisciplinary teams to select and implement those changes that they feel will improve their case handling.

340. Frangia, G.W., and Reisinger, J.J. *Journal of Clinical Child Psychology* 8(1):64-68, 1979.

Describes a modular structured preschool intervention system which utilized professionals as resource staff to train and supervise parent-consumers in implementing and evaluating therapeutic procedures that the parents apply with their own children. Some of the unique aspects of this parent-child system are explained in terms of addressing traditional and typical problems that have plagued approaches to mental health service delivery: delay in providing service, insufficient professional personpower, and failure to utilize the research literature in developing intervention strategies. Conclusions stress the necessity of improved funding formulas, this system's cost-benefit value, and the advantage of consumer participation in treatment programming operations.

341. Gerber, B.M., and Goldberg, H.K. Psychiatric consultation in a school program for multihandicapped deaf children. *American Annals of the Deaf* 125(5):579-585, 1980.

Issues of role identity and role negotiation in establishing a viable psychiatric consultation contract with a school program for multihandicapped deaf children are explored. Effective mental health consultation requires attention to factors which influence the

consultant-consultee relationships. Guidelines for dealing with the consequences of role confusion and conflict in this consultation relationship are presented. Emphasis is placed on the importance of gathering sufficient information about the school setting and its administrative structure, the teachers and their attitudes and educational objectives, and the children and the effects of their handicaps on developmental and family processes. A collaborative model is recommended for engaging participants in crucial role clarification problems in the special education setting where staff is already struggling with problems of role diffusion and identity. (abs.)

342. Gumaer, J. Educators' study selection and evaluation of outcome in school consultation. *Personnel and Guidance Journal* 59(2):117-119, 1980.

Identifies consultant functions as (1) self-assessment of one's personality and professional philosophy; and (2) understanding the process and procedures for identifying prospective consultees, selecting persons for consultation, and evaluating outcomes of consultation. Research efforts regarding the selection of consultees and evaluation of outcomes are reviewed.

343. Kandler, H.O. Comprehensive mental health consultation in high schools. *Adolescent Psychiatry* 7:85-111, 1979.

Because of the tendency to label as "badly behaved" children with real social or psychological problems, there is a need for comprehensive mental health services in schools. The history and current practices in this area are reviewed, focusing on philosophies of intervention/consultation, individual evaluation and treatment, psychoanalytically oriented supervision of school staff, and expert consultation. An example of a school mental health service that has operated as an extension of a clinic for over 10 years is provided. Teams go into schools to provide various services, including psychiatric and psychological evaluations, brief psychotherapy sessions, consultations with school staff, seminars for guidance personnel, classroom discussions with students, and group therapy. Roles of the mental health consultant in each of these areas are outlined, and case examples of types of consultation are provided. Other issues examined include school staff-consultant relationships, problems in the provision of services, and staff support and administrative power. The need for further research on what makes a good school and on how mental health professionals can contribute to the effectiveness of education is emphasized.

344. Kavanagh, T.E.; Freiman, A.B.; and Mossip, C.E. Development of problem-solving teams to assist children in the classroom. *New Jersey Journal of School Psychology* 1:54-61, 1982.

Discusses the development and implementation of the Child Assistance Program (CAP), a consultation-based system for aiding children with physical, mental, emotional, or social problems. The need for such a program stems from a shortage of trained personnel, the implementation of Public Law 94-142, and teacher dissatisfaction with child study team functioning. In 1978, a New Jersey school system composed of five elementary, one middle, and one high school began to develop CAP by revising the child study team service delivery system. CAP was based on the concept that consumers of an innovation (administrator, teachers, and child study team members) should participate in its planning, implementation, and evaluation. CAP meetings are called when a child has a problem that cannot be solved by the teacher, principal, or child study team building consultant. These persons meet with parents and any other staff members who may be helpful to define the problem behavior, set a goal, brainstorm on solutions, implement the solutions, and evaluate subsequent behavior. The CAP approach has been successful and has promoted cooperation among school staff and parents.

345. Kris, K. The school consultant as an object for externalization. *Psychoanalytic Study of the Child* 33:641-651, 1978.

The psychoanalytic concept of externalization is applied to an understanding of the process of psychiatric consultation in schools, and its use in several clinical examples and in published descriptions of school consultation is illustrated. Externalization occurs within the context of an object relationship and consists of the attribution of a part of the mental structures or their contents to the object. The need to protect the consultant from inadvertently accepting an omnipotent ego and superego role, as defined by the consultee's externalizations (thereby deviating from the ego attitude of collaboration), is emphasized.

346. Mace, F.C.; Cancelli, A.A.; and Manos, M.J. Increasing teacher delivery of contingent praise and contingent materials using consultant feedback and praise. *School of Psychology Review* 12(3):340-346, 1983.

Extended the work of A. Cossart et al. by (1) broadening the range of teacher behaviors to include both the use of contingent praise and contingent educational materials, (2) presenting a procedure that was efficient in terms of demands on teacher and

consultant time, and (3) illustrating the delivery of services using a behavioral consultation model with an actual client in the natural environment. Three teaching staff members and a 10-year-old Pakistani boy with academic and behavior problems participated in a case study. Observation data of teacher-student interactions were taken two or three times a week over a 6-week period by a consultant. The consultant also collected data on the frequency of staff delivery of praise and extra educational materials that the pupil found reinforcing. Results indicate that consultant feedback and praise immediately following each observation period had a positive effect on staff delivery of contingent reinforcing educational materials. There was a significant reduction in behavior of the pupils that had been targeted as undesirable. It is suggested that immediate feedback and praise may not be required to achieve positive results and future studies might try a more flexible or intermittent schedule.

347. McGlothlin, J.E. The School Consultation Committee: An approach implementing a teacher consultation model. *Behavioral Disorders* 6(2):101-107, 1981.

Discusses the establishment of the School Consultation Committee, which is composed of skilled regular and special education teachers, the building principal, and ancillary personnel. An outside consultant trains the committee to screen referrals; to pinpoint and assess discrepancies between teacher expectations and child performance; and to design, implement, monitor, and evaluate intervention plans. Preliminary results indicate that the committee is an effective approach for supporting behaviorally disordered pupils in the educational mainstream.

348. Neel, R.S. How to put the consultant to work in consulting teaching. *Behavioral Disorders* 6(2):78-81, 1981.

Describes three approaches to consulting with teachers. In the purchase model, the classroom teacher orders a service that is delivered by the consulting professional. In the doctor-patient model the consultant provides a diagnosis and a prescription for the problem experienced by the teacher. The process consultation model emphasizes helping the teacher solve his or her own problems. General skill areas necessary for effective process consultation are discussed.

349. Pryzwansky, W.B., and Rzepski, B. School-based teams: An untapped resource for consultation and technical assistance. *School Psychology Review* 12(2):174-179, 1983.

Argues that if school-based teams are going to satisfy optimal cost-effectiveness criteria while being recognized by school staff

as a general resource, rather than as serving a restricted aspect of the schooling enterprise, their functions must be expanded. Some examples of activities in the consultation and technical assistance areas that could be adopted by school-based teams are presented.

350. Reid, E.A. The college psychiatrist as a consultant. *Psychiatric Annals* 8(4):19-23, 1978.

The three major roles of the college psychiatrist are identified as direct work with individual patients, consultation with someone within the university about an individual or group that is presenting problems, and general consultation or teaching without reference to a specific clinical problem. The question of conflict among these roles is discussed, and the primacy of confidentiality between the psychiatrist and individual patient is urged. It is suggested that the consulting psychiatrist should remember that college administrators are professionals with expertise in areas that the psychiatrist cannot claim. It is also noted that educational consultation and teaching can add depth to the psychiatrist's knowledge of the college community that can enhance both teaching and patient care.

351. Safyan, P.; Barrier, R.; and Sturm, J.A. Adjusted adolescent reaction: A preventive model? *Corrective and Social Psychiatry* 24(1):38-44, 1978.

A panel discussion of the adjusted adolescent reaction as a model of secondary prevention is described, and a consultation program in a secondary school is reviewed. Major goals of the program were to reduce the distance between those in need of services and service providers and to reduce the stigma of receiving mental health services. The importance of the peer group in identification of adolescents needing mental health services and in promoting mental health of adolescents is emphasized. Limitations of the program are evaluated.

352. Siegel, D. Help for learning disabled college students. *American Education* 15(6):17-21, 1979.

A special program designed to help college students who either have learning disabilities or emotional problems is described. The Learning Opportunities Center for Special Needs Community College Students at Kingsborough Community College in Brooklyn, New York, is designed to help students develop greater self-confidence and competence. Among the procedures used are individual and group counseling, direct classroom intervention, faculty orientation and consultation, and bypass techniques and materials. Students accepted in the program cooperate with the

staff in developing an Individual Educational Plan, listing skills to be strengthened and expected progress. Specific cases are described which illustrate the program's success in bringing emotional, social, and learning satisfactions to the students.

353. Solyom, A.E. Mental health consultation in infant day care: A new frontier of prevention. *Infant Mental Health Journal* 2(3):188-197, 1981.

The mental health aspects of infant day care are discussed emphasizing the fact that mental health input into the design, implementation, and ongoing supervision/evaluation of the majority of daycare programs is minimal at the present time. The following three criteria are proposed for judging the adequacy of mental health input in a daycare program: (1) ongoing mental health consultation to the caregiver staff on a weekly basis and by the same clinician; (2) assignment of primary caregivers to the infants; (3) periodic naturalistic observations of the infants to be recorded and discussed by the caregivers. It is postulated that consultation to the caregiver staff of infant daycare programs represents the opportunity to establish a new frontier of prevention. Therefore, the mental health professional should consider it a goal that every infant daycare setting would have a mental health clinician as a consultant. The methods, preventive functions, and manpower aspects of such consultation work are discussed. (abs.)

354. Walizer, E.H. Achieving success in posttreatment educational placements. *Child Welfare* 59(5):299-309, 1980.

The attitudes and actions that foster positive school adjustment in the behaviorally disturbed adolescent following residential treatment are examined. The placement worker must first consider the assistant/advocate/antagonist range of behaviors in establishing a role and attitude toward the educational establishment. In consultation with the youth and his or her family, choice of placement may then be made, with choices ranging from regular public school classes to work/study programs to nonschool job training programs. The student's schedule should be planned with an eye to maximizing the potential for success. Sharing of information with teachers in conference sessions is discussed. Of particular importance is the issue of confidentiality.

355. Walker, A.P., and Sperber, Z. The mental health professional without portfolio on the high school campus. *Journal of Clinical Child Psychology* 7(1):25-28, 1978.

The development of discussion groups organized to alleviate tensions at two high schools forced to share a single campus is

described. The students, who were from differing ethnic and socioeconomic groups, coexisted uneasily. In the face of growing tensions, mental health professionals from the local community mental health facility joined with teachers and counselors at the merged high school to initiate a program of rap groups for the students. Each of the groups was coded by a mental health professional and a teacher from the high school. Among the most challenging problems was the co-leader relationship itself. The patterns of consultation and mutual supervision which evolved are discussed. (abs.)

356. Warm, T.R. An approach to psychiatric school consultation: What's good about bad behavior. *Journal of the American Academy of Child Psychiatry* 17(4):708-716, 1978.

Experience with psychiatric consultation in the Cleveland Public Schools has shown that teachers are helped by understanding the defensive use of a pupil's behavior. The discovery of what is adaptive (good) about disruptive (bad) behavior can be enhanced by the recognition of common defensive behavioral patterns and their underlying causes. Examples are given to illustrate both the concepts and the consultation process. (abs.)

See also:

1, 2, 3, 4, 10, 15, 17, 27, 28, 32, 50, 60, 61, 62, 66, 67, 68, 69, 70, 71, 72, 73, 74, 76, 77, 78, 79, 80, 81, 82, 84, 87, 88, 89, 112, 232, 239, 240, 244, 248, 252, 254, 255, 260, 261, 262, 263, 264, 265, 267, 268, 269, 278, 287, 291, 293, 294, 297, 440, 441, 442, 453, 465, 469, 472, 478, 484, 487, 494, 498, 505, 514, 526, 534, 535, 542, 549, 552, 553, 554, 556, 560, 566, 567, 570, 571, 572, 573, 574, 579, 580, 581, 583, 584, 585, 595, 597, 598, 603, 607, 608, 610, 612, 613, 614, 620, 623, 626, 629, 630, 639, 642, 643, 645, 651, 652, 653, 661, 669, 670, 679, 680, 686, 687, 688, 689, 690, 691, 693, 695, 696, 697, 698, 701, 702, 704, 705, 708, 713, 715, 716, 717, 718, 720, 724, 728, 730, 737, 741, 742, 744, 748, 750, 751, 752, 754, 755, 759, 764, 765, 766, 767, 768, 769, 771, 773, 775, 776, 777, 778, 780, 781, 782, 783, 785, 789, 790, 793, 794, 799, 800, 801, 803, 805, 806, 809, 814, 823, 827, 829, 833, 848, 850, 851, 853.

Geriatric Settings

357. Austin, M.J., and Kosberg, J.I. Social work consultation to nursing homes: A study. *Health and Social Work* 3(1): 60-78, 1978.

Of 91 social work consultants to nursing homes in the Southeast who received a questionnaire, 39 responded. Case consultation was most frequently offered, followed by process and program consultation. There was a limited use of group work. A basic study of gerontology should be required in schools of social work; currently such training is offered on an elective basis.

358. Berkman, B.; Campion, E.; Swagerty, E.; and Goldman, M. Geriatric consultation team: Alternate approach to social work discharge planning. *Journal of Gerontological Social Work* 5(3):77-88, 1983.

Social work discharge planning services as part of a geriatric consultation team were compared to traditional social work discharge planning for 94 hospital patients aged 75 years and older. Findings indicate a more effective pattern of discharge planning through the team approach. Earlier identification and evaluation of functions, leading to a comprehensive view of the elderly, resulted in utilization of more social-health services and reduced early recurrent readmission.

359. Cheah, K.-C.; Baldrige, J.A.; and Beard, O.W. Geriatric evaluation unit of a medical service: Role of a geropsychiatrist. *Journal of Gerontology* 34(1):41-45, 1979.

Psychiatric evaluations of 136 patients ranging from 48 to 94 years of age were analyzed. Psychiatric evaluation was included as part of the complete geriatric workup done on patients transferred to a medical geriatric evaluation unit after acute care in medical and surgical services. Results indicate that a significant percentage of the patients had psychiatric problems. It was found that 19.1 percent were free of psychiatric problems, 58.8 percent had organic brain syndrome, 36.8 percent had dysphoria depression, 3.7 percent were paranoid, 8.1 percent suffered from alcohol abuse, and 18.3 percent of those married had marital maladjustment. It is noted that the role of the geropsychiatrist includes diagnosing, participating in psychiatric management, consulting, and supervising psychiatric evaluation by other team members. He is an essential member of the geriatric team since proper recognition and treatment of psychiatric problems are necessary to complete treatment and to make optimum disposition. (abs.)

360. Cohen, G:D. An alternative setting for community-based geropsychiatric care. *International Journal of Mental Health* 8(3-4):173-184, 1980.

An alternative site for delivering psychiatric services to older people in the community is addressed. Emphasis is on a clinic within the senior citizen housing project to illustrate opportunities for more effective care than can be provided away from such traditional facilities as the mental health clinic or the outpatient department of the psychiatric or general hospital. Services include individual psychotherapy sessions in the clinic or on home visits, consultation, and educational programs. Financing of the program is via Department of Housing and Urban Development funds.

361. Finkel, S.I. Psychiatric consultation in a community agency serving the elderly. *Hospital and Community Psychiatry* 31(8):551-554, 1980.

A psychiatric consultation in a community agency serving the elderly is described. It is noted that although elderly people have a higher incidence of mental disorders than other age groups, few programs have been developed to meet their mental health needs. The program of the Council for Jewish Elderly in Chicago, which provides comprehensive services and care for the elderly and which focuses on prevention of psychiatric illness, is described. The functions of the psychiatrist consultant to this program include evaluating selected clients, working with individual physicians and agencies to coordinate psychiatric services, conducting educational activities for agency staff, providing consultation to the agency administration, and participating in the evaluation of services. (abs.)

362. Fisher, R.H., and Shedletsky, R. A retrospective study of terminal care of hospitalized elderly. *Essence* 3(2): 91-100, 1979.

Data on 486 deaths occurring from 1973 to 1976 in a 530-bed Canadian geriatric unit were analyzed to assess the quality of care given to terminally ill patients. It was found that only a minority of the patients received narcotic analgesics or were treated with other than supportive therapy. Many patients had no family contact, a factor which is considered important in the dying process. The data suggest the need for a multidisciplinary consultative team to support ward care of terminally ill geriatric patients so that such areas as emotional distress, family, and religious needs are included in addition to the purely medical aspects of treatment.

363. Gurian, B. Mental health outreach and consultation services for the elderly. *Hospital and Community Psychiatry* 33(2):142-147, 1982.

The elderly are generally acknowledged to be at high risk for developing mental illness. Yet most elderly individuals do not voluntarily ask for psychiatric services, however great their need. Moreover, they are reluctant to deal with even one member of the health care network, much less an array of social service providers in a number of service settings. Outreach, therefore, has become the most successful method for ensuring that services reach as many needy elderly persons as possible. The author discusses the development of outreach services beginning with the establishment of the community mental health movement in the 1960's. A number of issues important to program planning are discussed, as are some of the barriers to accessibility for aged clients. The author describes in detail the geriatric outreach program of the Massachusetts Mental Health Center and offers a case study of how outreach affected one aged couple.

364. Jacobson, S.B. A mental health team approach in a voluntary nursing home. *Gerontological Society: 31st Annual Scientific Meeting* 18(5, Part 2):86, 1978.

A summary of a paper read at the 31st Annual Meeting of the Gerontological Society, held in Dallas, November 1978, is presented. A mental health team approach in a voluntary nursing home was described. The team consisted of a psychiatrist, a psychiatric nurse, and a psychiatric social worker. The team screened questionable applications for admission and evaluated selected applicants, responded to consultation requests and recommended or provided appropriate therapeutic intervention, followed up all referred cases, and conducted regularly scheduled case conferences. Team members also counseled families, consulted with staff regarding all aspects of resident care, and participated in in-service training programs. Each team member assumed other functions relevant to his other discipline; the availability of a psychiatric nurse was particularly valuable in the monitoring of residents receiving psychotropic drugs. It was concluded that the team approach has resulted in more effective psychiatric care at the Daughters of Jacob Geriatric Center (Bronx, N.Y.), and in a general improvement in the mental health of all of its residents. (abs.)

365. Jellinek, T., and Tennstedt, S.L. Prevention of chronicity in the nursing home. *Psychiatric Annals* 10(9):37-44, 1980.

The experience of one mental health center in providing treatment and mental health consultation services to nursing homes, with a major goal of prevention of chronicity, is described. The nursing home environment is discussed as it affects the processes of adaptation to losses in the elderly in the biological, social, and psychological spheres. In view of the importance of environmental factors, including staff roles and relationships, major program goals included education of staffs on mental health needs of residents, alteration of the nursing home milieu to meet these needs, and provision of direct clinical services to residents needing specialized treatment. Client-centered and consultee-centered case consultations were provided; staff development programs were offered; and administrative consultations were undertaken. Illustrative case consultations involving lack of motivation, increasing disorientation, and auditory hallucinations are presented.

366. Krakowski, A.J. Psychiatric consultation for the geriatric population in the general hospital. *Bibliotheca Psychiatrica* 159:163-185, 1979.

The first part of this paper is based on a study by the author in 1975-1976. The conclusions were that liaison psychiatry with geriatric patients differs from that with other age groups in the following ways: (1) referrals occur primarily when behavior becomes disturbing; (2) organic causes are often overrated but psychological and social causes and functional disorders are underestimated; (3) psychopharmaceutical agents and vasodilators are overused, while psychotherapy and other forms of treatment are underutilized. Attitudes toward consultations among these patients, their families, and consultees do not differ from those of younger groups. Liaison psychiatry with a situation-oriented approach is well suited to the needs of all concerned. Review of the psychosomatic parameters of aging is summarized as a basis of the proposed psychosomatic differential model for management.

367. Miller, D.B. Reflections concerning an activity consultant by a nursing home administrator. *American Journal of Occupational Therapy* 32(6):375-380, 1978.

Discusses problems a therapist can expect as a part-time consultant in a nursing home and argues that activities can be helpful in counteracting physical problems and especially depression and withdrawal.

368. Petry, S., and Gutheil, T.G. The hidden psychology of nursing home consultation. *Transnational Mental Health Research Newsletter* 21(1):6-9, 1979.

The dynamics of nursing home consultation are illustrated in a case report of a consultation involving a chronically mentally ill woman transferred to the nursing home following 20 years of hospitalization. Exploration of aspects of the patient's condition revealed an adaptational delay in response to changes which had been made in the facility's physical plant which had in turn affected spontaneous group formation among the residents. The consultative process in this case involved elements of placebo theory, family therapy, and group process. Successful intervention required identification and addressing of the hidden psychology of the institution. (abs.)

See also:

96, 162, 280, 290, 293, 475, 479, 617, 636, 714, 787.

Governmental Settings

369. Chaplin, G. Power on the couch. *Washington Post Magazine* Aug. 19, 1979. pp. 10-12.

The consulting work of Bertram Brown, former head of NIMH, with government administrators and VIP's is described, and the anxiety and depression which result from a variety of high stress situations encountered by those pursuing power in Washington, D.C., are discussed. The distinction between clinical paranoia and the "trained paranoia" necessary for survival in power politics is examined as well as the problem of keeping such trained paranoia out of one's personal life. The effects of the post-Watergate general lack of esteem for the government on the self-esteem of government administrators and VIP's are discussed.

See also:

13, 250, 433.

Hospitals and Health Agencies

370. Albino, J.E. Educational psychologists in the health sciences: Current roles and training needs. *Educational Psychologist* 15(2):125-133, 1980.

Roles and responsibilities of educational psychologists employed in health professions settings are discussed with special attention to implications for doctoral level training. Four areas of

competency are described as essential for most positions in the health sciences: consultation skills, program evaluation, test development and research design, and learning theories and applications. Finally, some suggestions are made for traditional educational psychology departments interested in providing improved preparation and training for graduates planning to enter health fields. (abs.)

371. Ames, D.A. Developing a psychiatric inpatient service in a rural area. *Hospital and Community Psychiatry* 29(12): 787-791, 1978.

The development of an inpatient psychiatric service in a community hospital in Appalachia is described. The program was built on existing mental health components in the hospital, a comprehensive alcoholism program and an inservice training program for general duty nurses. In its first phase, the program offered a consultation service to help physicians deal with emotional problems of medical patients and a daytime therapy program for selected patients referred by the consultation service. In the second phase, psychiatric patients were admitted directly from the community and placed in wards throughout the hospital. Eventually a separate 23-bed psychiatric unit was opened. Between 1973 and 1976 more than 2,200 patients were treated by the therapy service or as psychiatric inpatients. A continuing shortage of nurses and other problems that occurred during each phase of development are discussed, and the beneficial impact of the program on the hospital and community is described. (abs.)

372. Brimblecombe, F.W. The parent-professional partnership in early intervention for the mentally handicapped: Early partnership. *Australian Citizen Limited* 6(1):18-22, 1979.

The program for mentally retarded children and their parents at Honeylands in Exeter, England, is described. The program was designed to enable families to achieve skills, self-reliance, and confidence in providing for their own needs and in seeking and obtaining needed services. The Honeylands facility serves as a resource center in which a multidisciplinary staff aids parents and other family members in understanding the nature of the handicap, in learning skills to aid the children in maximizing their potential, and in providing support through counseling, consultation, and self-help groups.

373. Brown, A. A case study in family systems consultation for community health nurses working with Sudden Infant Death Syndrome (SIDS) families. *Family Therapy* 5(3):233-244, 1978.

Family systems consultation, based on the Bowen Family Systems Theory, is described in its application by community health nurses working with Sudden Infant Death Syndrome (SIDS) families. The sudden death of an infant activates in couples the instinctual emotional feeling complex that Bowen views as a major premise that guides human relationship behavior. The emotional shock wave puts families in disequilibrium because the dependency of family members on one another is challenged and undercut by the death. Physical or emotional symptoms may arise in other family members, including drinking, school or business failure, depression, psychotic episodes, or increased marital stress. A case study of a SIDS counseling and information program is described in terms of the population served and the delivery system. A strategy to simultaneously train community health nurses in family systems intervention and modify the organizational public health system is outlined. Implications for family systems consultation with special family mental health populations are emphasized. (abs.)

374. Bullock, D., and Kobayashi, K. The use of live consultation in family therapy. *Family Therapy* 5(3):245-250, 1978.

Guidelines are presented for therapists who are beginning to use the live consultation model. In live consultation, a therapist and a consultant who are peers in approach, knowledge, and skill collaborate to increase family motivation and decrease resistance. The consultant views the session from behind a one-way mirror to intervene at strategic points. Points of interventions and the pitfalls of the technique are described. (abs.)

375. Chapman, S. How far can you go in treating emotional problems? *Legal Aspects of Medical Practice* 7(9):23-27, 1979.

Legal considerations which must be taken into account by the general practitioner when treating patients with emotional problems are examined. Some general guidelines to avoid liability include referring almost all suicide threats and referring all persons diagnosed as schizophrenic, unless the person has been previously treated and seems to be stabilized, to psychiatrists. Referral is extremely important with youngsters or middle-aged people going into depression. Lawsuits have made clear the physician's duty to warn third parties of the danger a patient may represent. A physician who continues to treat an emotionally

disturbed patient may be sued if the patient harms self or others, based on the standard of care that requires consultation with a specialist or referral of a patient to that specialist.

376. Charbonnier, J.-F.; Planche, R.; and Porot, M. The evolution of the psychiatric consultation within the general hospital. *Annales Medico-Psychologiques* 138(6):657-662, 1980.

Describes the growing reliance of general hospitals on psychiatric experts and criticizes unnecessary psychiatric involvement. Previously psychiatrists were routinely involved in suicide cases only, but they are now asked for advice for subjective syndromes (e.g., pain without immediate organic cause, vertigo, pseudo-loss of consciousness); somatic illnesses; chronic illnesses; and changes in general health, especially when asthenia, loss of appetite, and weight loss are involved. Many psychiatric consultations are unnecessary, and psychiatrists find themselves visiting surprised patients who are ill-prepared for the visit. It is argued that if psychiatric consultation is truly required, the patient's bedside is the appropriate place: it is less threatening than the psychiatric ward, permits the psychiatrist to observe the patient in the usual environment, and also permits consultation with other medical personnel.

377. Coleman, J.V.; Patrick, D.L.; Eagle, J.; and Hermalin, J.A. Collaboration, consultation and referral in an integrated health-mental health program at an HMO. *Social Work and Health Care* 5(1):83-96, 1979.

The paper describes interactions between primary care physicians (PCPs) and mental health clinicians (MHCs) in a "team collaborative model." A study of the interactions showed there were about two consultations a day with PCPs for each MHC, that they are largely unscheduled, took place mostly in PCP or MHC offices or in corridors, and increased in frequency over a 2-year period. Role definition was a continuing process; PCPs and MHCs each learned through repeated discussions what to expect from the other in patient care. It is found that a model with close working arrangements between PCPs and MHCs is of therapeutic value for that large population of emotionally disturbed patients seen often by PCPs, much less often by MHCs.

378. Field, G.; Allness, D.; and Knoedler, W. Application of the Training in Community Living Program to rural areas. *Journal of Community Psychology* 8(1):9-15, 1980.

Successful experiences in consulting with three rural Wisconsin counties to help them establish community treatment programs

modeled on Training in Community Living principles are described. Program principles of community treatment of the chronically disabled psychiatric patients are summarized to clarify the consultation process. The consultation process is described. Starting small, transposing program principles, side-by-side consultation and training, emotional support, and perseverance are identified as the factors which enabled the programs to be successful. It is concluded that the implementation of community treatment for chronically psychotic patients using the program model seems to be a realistic alternative for rural mental health programs. (abs.)

379. Firman, G.J., and Kaplan, M.P. Staff "splitting" on medical-surgical wards. *Psychiatry: Journal for the Study of Interpersonal Processes* 41(3):289-295, 1978.

Institutional and role issues pertaining to the nurse-physician relationship on the medical/surgical ward are discussed within the context of staff "splitting." During work on a psychiatric consultation/liaison service, it was found that the staff was often unable to arrive at a truly interdisciplinary approach to patient care, and care tended to follow a multidisciplinary pattern. Characteristically, nurses expressed certain patterns of complaining about the medical staff, although they were reluctant to raise their concerns directly with the physicians. The hierarchical structure of the ward, the nature of the work, inadequate competence in effective communication, and inadequate understanding/ discomfort with psychiatry on the part of the physician contribute to splitting; while personality characteristics, role expectations, and the institutional role tend to prevent assertiveness and foster resentment on the part of the nurses. These factors in turn contribute to the occurrence of splitting and projective identification. Regular conferences involving all of the caretaking staff, centering on role and patient care, planning issues, and utilizing a variety of psychotherapeutic techniques, can aid in the achievement of a truly interdisciplinary approach. (abs.)

380. Freyberger, H.; Ludwig, M.; Mangels, M.; and Neuhaus, P. Consultation/liaison psychiatry activities in renal transplant unit. *Psychotherapy and Psychosomatics* 32: 157-163, 1979.

Consultation/liaison psychiatric activities in the renal transplant unit at Hannover Medical School in West Germany are described. The activities with regard to patients' care include the group session, with particular regard to dealing with patients' denial; the indirect and direct psychotherapeutic interventions; consultation and counseling; and dealing with live donors and potential

renal transplant patients. Consultation/liaison psychiatric activity includes teaching procedures and Balint group work. It is concluded that the field of surgery can represent a very promising one with regard to consultation/liaison psychiatry. (abs.)

381. Funk, J.B. Consultation in the management of sexual molestation. *Journal of Clinical Child Psychology* 10(2):83-85, 1981.

Outlines consultative procedures that will enable mental health professionals to help health professionals facilitate parental coping so that parents can positively influence the child's reaction. A consultative approach to management of a single, non-violent, nonincestual sexual molestation of a young child is described.

382. Gabinet, L., and Friedson, W. The impact of ward dynamics on psychiatric consultation and liaison. *Comprehensive Psychiatry* 22(6):603-611, 1981.

Examines the characteristics of several medical and surgical services as they interact with psychiatric services. Physicians request psychiatric consultation when the patient's mental state endangers the healing process. When the danger is less serious, the overall responsibility doctors feel for their patient influences the level of their interest in the patient's psychosocial status. Each service has its own combination of staff personalities, distribution of responsibility among disciplines, and administrative structure. These influence the nature of the consultation/liaison work that can be done. A particular liaison intervention cannot be effective in all ward climates. Liaison activities must be designed for the milieu of the specific ward. Teaching should be directed toward the individuals who need and appreciate it most, who may be nurses on one ward, social workers on another, or physicians on the third.

383. Geist, R.A. Onset of chronic illness in children and adolescents: Psychotherapeutic and consultative intervention. *American Journal of Orthopsychiatry* 49(1):4-23, 1979.

The importance of psychological intervention at the onset of chronic illness in children and adolescents is discussed. It is shown that patients with disparate chronic illnesses exhibit specific and similar reactions during the onset of disease. Recommendations for psychotherapeutic and consultative management of the patient are offered, and consideration is given to the effects of such intervention on both patient and psychotherapist. (abs.)

384. Gelfand, R., and Kiely, W.F. Psychiatric consultation to a general hospital medical evaluation service. *General Hospital Psychiatry* 2(1):56-60, 1980.

Psychiatric consultation to a general hospital medical evaluation service was reviewed and compared with consultation patterns for general hospital inpatients and psychiatric emergency service patients. Results of a questionnaire survey indicated nearly one in five patients admitted to this acute medical service required psychiatric consultation. A study of those patients seen by psychiatric consultants is reported. The prevalence of depressive illness as well as the psychiatric hospitalization referral rate was substantially greater than in general hospital inpatient or psychiatric emergency service evaluations. The implications of this relatively new area of consultation/liaison for hospital staffing and medical education are discussed. (abs.)

385. Goldberg, R.J.; Tull, R.; Sullivan, N.; Wallace, S.; and Wool, M. Defining discipline roles in consultation psychiatry: The multidisciplinary team approach to psychosocial oncology. *General Hospital Psychiatry* 6(1):17-23, 1984.

Multiple mental health professions are often involved in the management of cancer patients. Psychiatry, psychology, social work, and nursing have all developed entrees to the medical setting that lead to clinical involvement of one or more of these professions at any given time. Much confusion remains about the specific contribution of these different mental health professions, and lack of role definition makes it difficult for programs for mental health services to be logically planned or for services already in place to be organized in a collaborative manner. While these disciplines have interacted formally and informally in a number of settings for many years, there have been few published attempts to delineate the unique contributions of each and to suggest a model for their collaborative interaction. This paper attempts to define the unique contributions of each of these disciplines in relation to an oncology consultation program in a general hospital setting. The definitions are proposed as a model that can be generalized to other consultation programs.

386. Greenhill, M.H. Models of liaison programs that address age and cultural differences in reaction to illness. *Bibliotheca Psychiatrica* 195:77-81, 1979.

The integral model, a recently developed method for delivery of mental health care for general hospital patients, is examined. The model places the patient's welfare above traditional medical protocol and considers psychological care a routine right of a

patient. Principal aspects of such care include initiation of the psychiatric consultation by any health professional in addition to the attending physician, and mandatory consultations on high risk categories of severe reaction to illness. Five major working components of the integral model are discussed. (abs.)

387. Grob, M.C. Bringing program evaluation and clinical practice together. *Journal of National Association of Private Psychiatric Hospitals* 10(2):34-41, 1979.

The development of an Evaluative Service Unit at McLean Hospital is described and its effect on treatment planning and programming is discussed. Program development has generated a variety of evaluative formats such as time limited studies, ongoing investigations, establishment of a data bank, consultive services, education, and training. The staff for the program includes social workers, a research psychologist, and support personnel. The organizational structure encourages continual collaboration with hospital staff as a means of utilizing study findings. It is concluded that the evaluation unit within a service delivery system helps to provide the avenue and technology for implementing changes in the interest of high quality patient care and innovative programming.

388. Guggenheim, F.G. A marketplace model of consultation psychiatry in the general hospital. *American Journal of Psychiatry* 135(11):1380-1383, 1978.

A model of psychiatric consultation with similarities between research and development, manufacturing, and merchandising phases is proposed. The manner in which internists and surgeons view potential psychiatric consultations is analogous to the way in which consumers evaluate a service or product in the marketplace. Factors that determine a purchase or a consultation request include perception of need, prior attitude and experience, projected image, availability, and cost/benefit ratio. It is concluded that despite its demonstrated benefit to comprehensive care and its relatively minuscule cost, consultation psychiatry continues to be underfunded, jeopardizing the activities of a viable and useful adjunct to patient care. (abs.)

389. Gustwick, G. Sexuality and the mentally retarded. *Journal of the Tennessee Medical Association* 71(8):611-612, 1978.

Current directions in the sexual education of the mentally retarded, with recognize that all people are sexual and encompass the concept of maleness/femaleness, are examined. When medical professionals are first consulted, they must facilitate

discussions on the realities of sexuality and the mentally retarded individual. Parents of the mentally retarded should be encouraged to have group discussions not only with other parents but also with people working with the mentally retarded. Sexuality instruction should consider effective instruction methods which relate to the learning behavior of the mentally retarded. Other suggestions for a humanistic approach to sexuality instruction for the mentally retarded are included.

390. Hale, M. Psychiatric complications in surgical ICU. *Journal of Continuing Education in Psychiatry* 38(2):46, 1978.

A 6-month retrospective study of psychiatric consultations in a surgical intensive care unit (ICU) is presented. Of 322 admissions, 22 required psychiatric consultations, and male patients predominated among these. It was found that patients requiring psychiatric assistance had longer ICU stays, an increased morbidity, and a mortality rate of 2.5:1 compared with all patients in the unit. Organic brain syndromes, anxiety, and depression accounted for a majority (77 percent) of consultations. While many patients experience difficulty with the mechanized environment of the ICU, those seen by the psychiatrist had in addition an increased rate of complications, including cardiac arrest. While staff and psychiatric alliances were rapidly formed to forestall further difficulties, the major tranquilizers, haloperidol and perphenazine, administered orally and intramuscularly, were extremely helpful in symptomatically alleviating these syndromes. (abs.)

391. Hartocollis, P. The hospital team and the conflict of professional disciplines: Psychologists versus psychiatrists. *Journal of National Association of Private Psychiatric Hospitals* 9(4):42-43, 1978.

The professional relationship between psychiatrists and psychologists in a hospital setting is described in terms of job descriptions, quality of treatment, and ideal working relations. The hospital is defined as a medical institution, with the psychiatrist functioning as team leader with overall accountability for the patient's total treatment to the community, referring physician, family, third-party payor, consulting colleagues, and hospital director. Psychologists are assigned to psychological testing, research, and conducting psychotherapy. Consequences of the concept of interchangeability of roles are noted.

392. Ireton, H., and Hilliard, R. Teaching behavioral medicine by consultation in the family practice center. *Journal of Family Practice* 17(1):93-97, 1983.

Presents a consultative model for individualized teaching of behavioral medicine to family practice residents, including the goals and general objectives of the rotation and the results of a systematic evaluation. The preceptor, a clinical psychologist, works with one resident at a time, sees the resident's patients with the resident, and consults with him or her regarding patient care and related issues. The preceptor is guided by three considerations: (1) the rotation goals and objectives, (2) the resident's expressed learning goals, and (3) the patient's problems and needs. At the beginning of the rotation, the preceptor interviews the resident regarding background and interests in medicine, family practice, and behavioral medicine and then asks the resident to complete a self-evaluation form on interest and skills in behavioral medicine. At the end of the rotation, the resident again completes the self-evaluation form. This model was used with ten 2nd-year residents who provided self-ratings during the rotation. Compared to ten residents not in the program, participants reported increased confidence and ability to deal with patients' psychological problems.

393. Jacobs, D.H.; Rogoff, J.; Donnelly, K.; Birnbaum, B.; and Russian, R. The neglected alliance: The inpatient unit as a consultant to referring therapists. *Hospital and Community Psychiatry* 33(5):377-381, 1982.

During 2 years of work on an inpatient psychiatry unit in a general hospital, the authors became impressed with how often patient-therapist difficulties preceded the need to hospitalize a patient. Difficulties in the therapeutic relationship sometimes precipitated the hospitalization; other times they were complicating factors. Unresolved difficulties in this relationship had to be addressed during hospitalization if inpatient treatment was to be successful. The authors present several typical cases that demonstrate different kinds of difficulties in the patient-therapist relationship and the use of consultation by an inpatient staff in resolving them. They conclude that an inpatient unit with sufficient staff should serve as a consultant to the referring therapist in almost every case.

394. Jellinek, M.S.; Herzog, D.B.; and Selter, L.F. A psychiatric consultation service for hospitalized children. *Psychosomatics* 22(1):29-33, 1981.

The authors describe the organization of the child psychiatric consultation service of the Massachusetts General Hospital. They

review the conceptual framework of consultation to pediatric inpatients and analyze a 9-month study of 72 consultations by categorizing them according to type or request for consultation. Liaison activities, designed to provide information and to help the staff tolerate stress, are exemplified in five brief case reports.

395. Kass, F.; Karasu, T.B.; and Walsh, T. Emergency room patients in concurrent therapy: A neglected clinical phenomenon. *American Journal of Psychiatry* 136(1):91-92, 1979.

The percentage of hospital emergency room patients who are already involved in psychiatric treatment was investigated and a rationale was developed for consultation. One-third of 100 patients who were interviewed were participating in concurrent psychiatric treatment. Exploration of the relationship between patient and therapist proved to be a valuable tool in formulating consultation and in ensuring continuity of care. (abs.)

396. Kavanaugh, J.G., Jr., and Volkan, V.D. Transsexualism and a new type of psychosurgery. *International Journal of Psychoanalytic Psychotherapy* 7:366-372, 1979.

Surgical procedures for transsexuals are viewed as a new kind of psychosurgery: surgical procedures for the sake of behavioral or emotional improvement. Clinical study reveals that these patients have borderline personality organization and are seeking to discard bad and aggressive features and to replace them with a new idealized perfection. Studies are reported which show that whatever their specific complaints, transsexuals have a desire for perfection which is not always openly admitted. In a followup of about 50 candidates seen for sex change in Johns Hopkins, only about half of whom had sex-change surgery, social circumstances of all improved slightly over their initial situation whether they had surgery or not. Further research in these areas is urged. It is recommended that psychiatrists consult on sex change operations.

397. Kielholz, P. The foundation, objectives, and activities of the International Committee for Prevention and Treatment of Depression. *Comprehensive Psychiatry* 21(6):469-474, 1980.

The development of an International Committee for Prevention and Treatment of Depression (PTD Committee), which grew out of findings that a substantial percentage of patients consulting a doctor suffered from depression and were treated by their practitioner, is reviewed. The purpose of the committee is to disseminate, particularly to general practitioners, information relating to the treatment of depression on an outpatient basis and to

promote closer cooperation between psychiatrists and nonpsychiatrists. This is done through seminars, audiovisual aids, and a bulletin. Studies designed to clarify the forms of depressive illnesses, as well as the severity being encountered and differences in treatment of depression in various countries, are mentioned.

398. Knauert, A.P., and Davidson, S.V. Maintaining the sanity of alcoholism counselors. *Family and Community Health* 2(2):65-70, 1979.

The stresses which result from dealing with alcoholic clients and which sometimes result in alcoholism professionals developing the burnout syndrome are reviewed, and ways in which alcoholism counselors can be helped to regenerate emotional resources are discussed. It is contended that trusting, nurturing, dependable colleagues are necessary for preventing burnout of counselors. Alcoholic treatment programs may encourage counselor regeneration via staff meetings specifically organized to talk about feelings, staff retreats, consultation services of Alcoholics Anonymous, and encouragement of religious or social affiliations among staff. Alcoholism counselors can also prevent burnout by defining roles and expectations with their clients, obtaining therapy for themselves when necessary, and obtaining adequate training as alcoholism counselors. (abs.)

399. Koldjeski, D. The mental health role of primary health care nurses. *Journal of Clinical Child Psychology* 7(1):37-39, 1978.

The nonpsychiatric profession of primary health care nursing and its contribution to mental health care is described. It is asserted that the nursing profession's mental health role can be expanded by extending the psychosocial base of concepts currently included in basic professional nursing education programs. Expansion of the mental health role would encompass comprehensive health assessments, with attention paid to emotional and mental health problems, management of less complex problems, and use of generic intervention strategies such as crisis intervention. Consultation from mental health professionals is essential. It is stated that the primary health care nurse is not expected to function as a mental health specialist. (abs.)

400. Koocher, G.P.; Sourkes, B.M.; and Keane, W.M. Pediatric oncology consultations: A generalizable model for medical settings. *Professional Psychology* 10(4):467-474, 1979.

The development of a psychological consultation service that effectively serves staff and patient needs in a complex pediatric oncology setting is described. The evolution of the consultation

service within the hospital setting led to the identification of the following principles that can be adapted to other medical settings: (1) regular communication between the psychologist and the front line patient care staff regarding the type of psychological problems encountered; (2) routine and predictable presence of the psychologist on the hospital ward; (3) use of teaching conferences or rounds; and (4) becoming an effective member of the medical team and mobilizing the team members in the patients' best interests. Reasons why the traditional medical or disease model of emotional disorders is often counterproductive in establishing an effective psychological consultation service in a medical setting are discussed.

401. Lefer, J., and Griffin, A. The psychoanalyst as consultant on a hemodialysis unit. *Contemporary Psychoanalysis* 14(1):155-166, 1978.

Discusses the value and necessity for the psychiatrist or psychoanalyst as consultant in the holistic management of organic illness. In hemodialysis, the patient suffers the ignominy of being an object attached to a machine. Delusions are created which, because of the necessity for life-sustaining machines, cannot be prevented. The psychiatrist is useful here as well as in educating hospital staff who are also subject to anxieties and morbid fears. Several case histories illustrate how the machine is received with loathing and dread and how the psychiatrist can be helpful.

402. Loos, J.C. Psychic stress in advanced medical care: The artificial kidney treatment. *Tijdschrift voor Psychiatrie (Meppel)* 20(6):347-362, 1978.

Problems of stress and psychiatric symptoms arising as a result of radical methods of medical treatment, specifically in a renal dialysis unit, are discussed and related to other patient groups in similar situations such as those under intensive, coronary, or respiratory care. The patient apparatus theme; adaptation problems, stress factors, and reactions to renal dialysis; and denial and avoidance behaviors are investigated. It is considered essential that renal dialysis units make use of psychiatric or medical/psychological consultation assistance for the psychological support of both patients and medical and nursing personnel.

403. Mayou, R.; Foster, A.; and Williamson, B. Medical care after myocardial infarction. *Journal of Psychosomatic Research* 23(1):23-26, 1979.

Three aspects of efficient and effective medical care to assist the recovery of myocardial infarction patients were examined: (1) advice and compliance; (2) consultation: extent and

determinants; and (3) detection of psychosocial complications. One hundred patients suffering a myocardial infarction were interviewed in the hospital and at 2 and 12 months after the infarct. Patients and families had only a limited recollection and understanding of medical advice, and compliance was frequently poor. Compliance did not correlate with any of the psychological or social measures, and continued consultation and treatment were not clearly related to the apparent medical or social problems. Despite considerable consultation during the year, doctors underestimated psychosocial morbidity. It is concluded that there are strong medical and cost-benefit arguments for introducing and evaluating simple routine rehabilitation programs designed to provide the right treatment for the right patients. (abs.)

404. Mendelsohn, I.E. Liaison psychiatry and the burn center. *Psychosomatics* 24(3):235-246, 1983.

This article presents case histories and descriptions of treatment during the four phases of burn recovery to illustrate the application of several psychotherapeutic approaches. How the liaison psychiatric team can contribute substantially to the management of psychological problems of both patients and staff is discussed.

405. Morrill, R.G. The future for mental health in primary health care programs. *American Journal of Psychiatry* 135(11):1351-1355, 1978.

The future of mental health care delivery within primary health care programs is discussed. Primary health care systems have been oriented toward specialization and solo practice, but are moving in the direction of primary care and group and organizational practice. New forms of mental health delivery are needed to maximize the potential of these new health care programs for mental health services. Integrated programs which bring mental health providers into the primary health care programs for direct services as well as consultation are described. Issues discussed include mutual roles, changes in service, the referral process, and provider relationships. The advantages of such integrated programs include decreased stigma, increased prevention through earlier detection and referral, increased family orientation, greater coordination of care, and less duplication of effort. (abs.)

406. Morrison, A.P. Medical student psychiatric education in neighborhood health settings. *Journal of Medical Education* 53(12):994-996, 1978.

Medical student placement in a neighborhood health center in which primary care services are offered is discussed as an elective alternative to clerkship rotations on inpatient psychiatric

wards for the teaching of clinical psychiatry. Because the goals of the center involve care of the whole family, consultation with other medical or mental health staff is often relevant to the student in relating to the patient in a family context. Because of this, the student learns about the services of the center or community agencies in relation to the family involved. Students are exposed to the special problems of minority groups through case conferences, administrative staff meetings, and the general ambience of the clinic. Students observe mental health services delivered by nonpsychiatrists. The respectful collaboration of psychiatrists with mental health workers, psychiatric nurses, psychologists, and education specialists is experienced as it is a part of the team approach to treatment which the center employs.

407. Papp, P. The Greek chorus and other techniques of paradoxical therapy. *Family Process* 19(1):45-57, 1980.

Some of the interventions developed at the Ackerman Brief Therapy Project in treating the families of symptomatic children are described. The interventions are based upon a differential diagnosis of the family system and upon an evaluation of that system's resistance to change. They are classified as compliance based or defiance based, depending upon the family's degree of anxiety, motivation, and resistance. Paradoxical interventions, which are defiance based, are used as a clinical tool in dealing with resistance and circumventing the power struggle between therapist and family. A consultation group acting as a Greek chorus underlines the therapist's interventions and comments on the consequences of systemic change. This group is also sometimes used to form a therapeutic triangle among the family, therapist, and group, with the therapist and group debating over the family's ability to change. (abs.)

408. Perotti, J., and Spangler, P.F. A consultative model for providing community services to the mentally retarded. *Hospital and Community Psychiatry* 34(10):964-965, 1983.

Describes a medical and behavioral consultation team that operates in Delaware County, Pa. The team consists of 12 medical and rehabilitation consultants, 4 behavior therapists, a psychologist, and a training professional. The functions of the team and its members are discussed in the context of a community-based service delivery system for the mentally retarded.

409. Pincus, H.A. Linking general health and mental health systems of care: Conceptual models of implementation. *American Journal of Psychiatry* 137(3):315-320, 1980.

Within the context of the rationale and need for a comprehensive health care system, conceptual models for moving mental health systems of care into the mainstream of general health service delivery are discussed. Linkages between mental health and general health systems are defined in terms of educational, functional, and contractual elements. Six conceptual models are then presented and exemplified: agreement, triage, service delivery team, consultation and service, supervision and education, and the integrated health care team. Choice of a model must take into account the population served, geography, management, financing mechanisms, philosophy of care, and the settings and levels of care. Future directions for research and evaluation in the area of comprehensive, coordinated, and holistic health care are delineated. (abs.)

410. Rae-Grant, N. Prevention: A multifaceted approach requiring multidisciplinary input. *Canada's Mental Health* 27(2):3-4, 1979.

The need for a multifaceted approach to mental health primary prevention interventions is emphasized, and the possibilities for various kinds of prevention programs are discussed. Two aspects of primary prevention are noted: efforts to focus on modifying the stressful environment and efforts designed to strengthen the capacities of individuals to cope. Several interventions during infancy, childhood, and old age are briefly described. It is noted that psychiatry, psychology, and social work input will be needed, not in direct services so much as in provision of a body of knowledge in a consultation capacity. People who have themselves mastered life crises such as bereavement, separation, divorce, unemployment, and retirement may be the most appropriate ones to help others deal more effectively with life crises.

411. Rittlemeyer, L.F., Jr., and Flynn, W.E. Psychiatric consultation in an HMO: A model for education in primary care. *American Journal of Psychiatry* 135(9):1089-1092, 1978.

A health maintenance organization (HMO) psychiatric consultation program based on a biopsychosocial model of illness which uses a liaison/consultation approach in an outpatient setting is described. The program is directed toward integrating psychiatric education and services with primary care in an HMO. It is asserted that the program can serve as a useful model for studying the validity and effectiveness of integrating psychiatric concepts with primary health care. (abs.)

412. Roberts, R.N., and Gordon, S.B. Reducing childhood nightmares subsequent to a burn trauma. *Child Behavior Therapy* 1(4):373-381, 1979.

The successful treatment of a 5-year-old girl who, subsequent to an accident in which she was severely burned, experienced nightmares and night terror as often as 15 to 20 times every night is described. In addition to the night terrors, she developed a strong phobic reaction to a wide range of fire-related stimuli. Treatment involved multiple stages which included a response prevention procedure extinction and systematic desensitization. Implications for behavioral medicine and early consultation and intervention by behavioral scientists in the medical problems in medical settings are discussed. (abs.)

413. Sanders, C.A. Reflections on psychiatry in the general-hospital setting. *Hospital and Community Psychiatry* 30(3):185-189, 1979.

The positive effects of consultative and liaison psychiatry linkages in the general hospital setting are discussed, as well as the problems of financing which derive from inequities of reimbursement for consultation and lack of payment for liaison services. Suggestions for educating psychiatrists are made, emphasizing that training should not be geared exclusively toward the psychiatrist's role as a primary caretaker. Medical schools should introduce students to the discipline and its interrelationships with other professions, and teaching hospitals should train the psychiatrist in the medical model. It is concluded that the future of general psychiatry does not lie in primary care but in its being an identified specialty closely allied to super-specialists and to primary caretakers alike. (abs.)

414. Schneeweiss, D., and Streltzer, J. Emergency psychiatric consultation: A case report. *International Journal of Psychiatry in Medicine* 10(2):135-143, 1981.

Unique difficulties which may be encountered in emergency psychiatric consultation are illustrated in a case report of a young male with multiple fractures whose demanding, abusive, hostile, and uncooperative behavior caused management difficulties for nursing staff and physicians. After 4 weeks of hospitalization, a crisis emerged: the patient spat on a nurse and had a physical altercation with his surgeon; the nurses threatened to resign, the surgeon refused to see the patient further, and the patient insisted on being discharged although his medical condition made this impossible. A decision was made to involuntarily commit the patient as a psychiatric patient and place him in physical restraints. The patient expressed extreme dislike of having his

freedom restricted and promised that he would control his behavior and comply with treatment and staff if let out of restraints. The patient remained cooperative for the remaining weeks of his hospitalization and no further problems arose. (abs.)

415. Selzer, M.A. The role of the consultant in the case conference: Some neglected aspects. *Psychiatry* 44(1): 60-68, 1981.

The case conference is a staple of academic life in psychiatry. On an inpatient service, the case conference holds the potential for uncovering the covert dynamics at work in the treatment setting; it is the task of the consultant who leads the conference to see that this potential is met. A major part of the consultant's work is bringing to life the hidden agendas of the conference. These agendas provide the key to identifying central conflicts which obstruct therapeutic work. Although most often these conflicts appear between staff and patient, they also arise among staff members as well as between the unit staff and the hospital administration.

416. Slaby, A.E.; Pottash, A.L.C.; and Black, H.R. Utilization of psychiatry in a primary care center. *Journal of Medical Education* 53(9):752-758, 1978.

The pattern of use of psychiatry over a 12-month period in a university-based primary care center is reported. Interest in pursuing careers in family practice and amount of time spent in the center were related to seeking consultation. All nurse practitioners and social workers sought psychiatric consultation. The majority of patients received care for their psychiatric problems by their primary care clinicians after consultation, rather than being referred to a traditional psychiatric clinic. (abs.)

417. Soreff, S.M. Psychiatric consultation in the emergency department. *Psychiatric Annals* 8(4):61-66, 1978.

The psychiatric consultation program to the emergency department of a major medical center involving patient evaluation, referral implementation, involvement with the community psychiatric treatment network, and liaison activity with the emergency department staff is described. It is noted that effective liaison work requires an appreciation of the structure and staff of the emergency department. It is suggested that the program, which includes joint conferences with division and department staff, participation in emergency medicine courses, and a commitment to psychiatric resident education, can be an exciting opportunity for psychiatry. It is concluded that this program

provides a model of the collaborative approach between the department of psychiatry and the emergency department.

418. Steffens, W. Comments on the role played by the physician in a psychiatric rehabilitation home. *Psychiatrische Praxis* (Stuttgart) 6(1):22-30, 1979.

Various aspects of psychiatric consultation in a psychiatric rehabilitation home are reviewed, and the role of the consulting physician is described. Consultation was undertaken with the aim of clarifying the dynamics of the patient-environment relationship in a rehabilitation home for patients with chronic schizophrenic psychoses. It is contended that the teamwork between the team and the consulting physician is endangered mainly by narcissistic tensions which originate in the basic disturbance of the schizophrenic patients and which represent a repetition of the pathogenic original patient scene. An essential prerequisite concerning these narcissistic tensions is that that team should learn to make use of the consulting physician as an auxiliary or supporting ego, while gradually evolving critical ego functions in the team itself. (abs.)

419. Suchotliff, L. Crisis induction and parental involvement: A prerequisite of a successful treatment in an inpatient setting. *Adolescence* 13(52):697-702, 1978.

The view that in residential treatment programs the relevance of the procedures and methods utilized in situations encountered on the outside are often lost sight of is explored. The utilization of a stress induction model in conjunction with parental consultation within an inpatient setting makes it a great deal easier to conceptualize the relationship between problems the child has in the program, how they are handled, and the way problems are dealt with at home. Involving the parents in dealing with family therapy program crises allows one to see firsthand how the family interacts under conditions of stress and permits systematic interventions into this system. If the goal is to return the child home, the parents and the child must be convinced that changes in behavior are a result of their methods of interacting with each other and not merely a result of contact with new sympathetic adults outside the home. (abs.)

420. Wasylenki, D., and Harrison, M.K. Consultation-liaison psychiatry in a chronic care hospital: The consultation function. *Canadian Journal of Psychiatry* 26(2):96-100, 1981.

Reports that although 60 percent of consultation requests from 70 patients in a chronic care and rehabilitation hospital were for

depression, only 8.6 percent of patients seen received a diagnosis of affective disorder and 51.4 percent did not receive a formal psychiatric diagnosis and were found to present problems in adapting to chronic disabling illnesses. It is concluded that in this population (1) psychotropic medication should be used judiciously, (2) interpersonal and milieu approaches should be emphasized, and (3) the psychiatric consultant should maintain an optimistic, therapeutic attitude. (abs.)

421. Weissberg, M.P. Emergency room medical clearance: An educational problem. *American Journal of Psychiatry* 136(6):787-790, 1979.

The use of emergency room settings for interspecialty collaboration and training of psychiatrists and clinical physicians is described. The overuse of the term "medically clear," especially in emergency room settings, may indicate difficulties in medical education and in the consultation referral practices between psychiatry and other specialties and may also result in poor patient care. Nonpsychiatric physicians may prematurely refer patients as medically clear because of their unfamiliarity or discomfort with clinical psychiatry; psychiatrists often ask for medical clearance of patients to hide their discomfort with or antipathy toward clinical medicine. It is concluded that the use of emergency room settings helps minimize the underlying difficulties that lead to the use of this term by fostering psychiatric skills in nonpsychiatrists and a sense of medical identity in psychiatrists. (abs.)

422. Wertlieb, D. A preventive health paradigm for health care psychologists. *Professional Psychology* 10(4):548-557, 1979.

A preventive health paradigm for health care psychologists is developed by adopting a biopsychosocial perspective on health and illness and by building on public health and preventive mental health models of primary, secondary, and tertiary prevention. Primary prevention in health care psychology consists of stress reduction and promotion of competency and health. Examples include prepared childbirth and early parent education groups. Secondary prevention involves early intervention aimed at reducing deleterious physical and psychosocial effects of illness in such situations as preparing surgery patients or helping people experiencing marital separation. Tertiary prevention involved helping individuals to cope with chronic disease. Other avenues for preventive health activity by psychologists in health care settings include (1) traditional liaison/consultation work, (2) traditional mental health services (psychotherapy), (3) interventions to change health care provider attitudes and behavior,

(4) changing patient attitudes and behaviors, (5) changing health care delivery system behavior, and (6) basic and applied research.

423. Winstead, D.K.; Gilmore, M.; Dollar, R.; and Miller, E. Hospice consultation team: A new multidisciplinary model. *General Hospital Psychiatry* 2(3):169-176, 1980.

The Hospice Consultation Team, New Orleans Veterans' Administration Medical Center, is described with special reference to its unique features as a combined consultation team/hospital-based home care program for the terminally ill. The use of such a model allows the development of this program by mobilizing existing resources and required no additional funds. Additionally, a consultation/liaison model encourages the continued participation of treating physician, nursing staff, and other team members and allows for their education in the treatment of the terminally ill. Most importantly, the care of the dying patient is improved and families are provided with the opportunity for counseling and assistance with bereavement following the death of their loved one. Cases are presented that illustrate the benefits of such an approach to the care of the dying patient and his family. (abs.)

424. Wise, T.N., and Goldberg, R.A. Organizing consultation-liaison services in the general hospital. *New Directions for Mental Health Services* 15:93-104, 1982.

In a general hospital, the emergency room and psychiatric consultation service are entry points for the identification and referral of many emotionally disturbed patients. The applicability of consultation-liaison psychiatry for the treatment of this population is advocated because it incorporates psychoanalytic concepts of psychosomatic disorders and psychophysiologic observations. The fragmentation of the doctor-patient relationship has led liaison physicians to develop new models, such as the biopsychological approach. Case examples are presented to illustrate liaison development and maintenance of the liaison relationship.

See also:

5, 6, 14, 17, 18, 20, 22, 26, 30, 34, 50, 59, 90, 92, 93, 94, 95, 97, 98, 99, 100, 101, 102, 103, 106, 107, 108, 109, 110, 111, 113, 115, 116, 117, 118, 120, 121, 122, 123, 124, 125, 126, 130, 134, 135, 136, 140, 141, 142, 143, 144, 147, 150, 151, 152, 154, 155, 156, 159, 162, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 177, 178, 179, 181, 182, 183, 184, 187, 188, 189, 190, 191, 193, 194, 195, 196, 197, 201, 202, 203, 204, 206, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 225, 226, 227, 228, 229, 234, 235, 238, 245, 246, 249, 258, 259, 263, 266, 270, 279, 283, 284, 288, 292, 302, 305, 366, 462, 463, 470, 472, 483,

486, 490, 499, 509, 512, 513, 515, 523, 524, 529, 530, 538, 540, 543, 548, 550, 555, 557, 560, 562, 565, 568, 569, 577, 578, 582, 588, 590, 591, 593, 594, 596, 599, 601, 605, 606, 609, 611, 615, 616, 618, 622, 624, 628, 631, 635, 638, 640, 641, 647, 648, 649, 650, 656, 659, 660, 662, 664, 665, 678, 680, 683, 710, 732, 772, 784, 788, 791, 803, 810, 813, 822, 824, 825, 842, 844, 845, 852, 854, 855.

Industrial and Business Settings

425. Akabas, S.H. Fieldwork in industrial settings: Opportunities, rewards, and dilemmas. *Journal of Education for Social Work* 14(3):13-19, 1978.

The role of the social worker in the industrial field setting is examined within the context of the Columbia University training program. With the increasing pressure on business to assume responsibility for the quality of life, an opportunity exists for schools of social work to define the potential of social service delivery and social policy in the work setting. Field work assignments of students have included social service interventions for high-risk disability employees, consultation for corporate community service funding decisions, evaluation of retirees and provision of linkages with community services, and provision of therapeutic interventions to emotionally troubled workers. Industrial social work provides a means for reaching new populations while facilitating the development of a great variety of social work skills including interviewing, assessment, outreach, crisis intervention, referral, counseling, contracting, research, and consultation. Entry into industrial social work, placement agreements, dilemmas of placement, and the supportive role of the school are also discussed.

426. Anthony, K.H. Creating the professional mystique: Marketing environmental psychology. *EDRA: Environmental Design Research Association* 13:62-69, 1982.

In response to Sommer's (1980) article, "Architecture, psychology: The passion has passed," the present article analyzes specific problems that have plagued consultations between behavioral scientists and practicing architects and suggests ways in which these difficulties can be resolved. Some modifications to the educational training of environmental psychologists are proposed to help make them more marketable in the business world.

427. Breed, W., and de Foe, J.R. Effecting media change: The role of cooperative consultation on alcohol topics. *Journal of Communication* 32(2):88-89, 1982.

Defines cooperative consultation as a shared and continuing exchange process between media personnel and a knowledge consultant that works to change certain media contents in a direction approved by both parties. A description is presented of a project that used research as a basic resource in changing media messages about drinking, while avoiding some of the pitfalls of traditional pressure group practices. It is noted that cooperative consultation on alcohol abuse is most effective in two situations-- providing objective information that gives authenticity to alcohol appearances and making latent contents manifest to the media staff, thus making them aware of problematic patterns.

428. DuPont, R.L., and Basen, M.M. Control of alcohol and drug abuse in industry--A literature review. *Public Health Reports* 95(2):137-148, 1980.

A report on a broad range of problems associated directly and indirectly with workers' use of alcohol and drugs not prescribed by a physician is presented. The extent of the problem in industry, industry's response to substance abuse, and several impacts and limitations of such programs are discussed. An employee's deteriorating job performance resulting from an underlying substance dependency represents the greatest risk because it is the most prevalent element of a drug or alcohol problem. Four models identified in a classification of occupational alcohol and drug abuse programs are consultation only, assessment and referral, diagnostic and referral, and diagnostic and treatment. A control program's goal should be to help people achieve and maintain satisfactory health and job performance, should focus on the causes of deteriorating health and job performance, and should adopt the strategy of constructive confrontation.

429. Kepner, E. The family and the firm: A coevolutionary perspective. *Organizational Dynamics* 12(1):57-70, 1983.

The unique nature of the family-owned firm has presented dilemmas and frustrations to those who manage, work in, and consult with such firms. Organizational theorists have found it difficult to apply their task-oriented, competency-based models to a business in which the boundaries between task and kinship considerations overlap. Practitioners who work with such organizations find that the types of interventions successful in other situations are likely to be rejected or to be found inadequate in dealing with the particular complexities involved. Founders are called on to make choices that put them in "no-win" double-bind situations. If

they base their decisions on what the firm needs, kinship bonds may be disrupted and damaged; if they choose to honor family bonds, the business is likely to suffer. The author attempts to expose the complexity of relational patterns between the firm and the family systems in general, their purpose as satisfiers of certain universal human needs, the way they are organized to perform their functions, and the cultural dimensions by which they regulate themselves and their development. Under each of these topics, ways are described in which the family's organization and culture are influenced by its relationship with a firm.

430. Leonards, J.T. Corporate psychology: An answer to occupational mental health. *Personnel and Guidance Journal* 60(1):47-51, 1981.

Suggests that corporate planners currently acknowledge that productivity is directly related to employee mental health and that, with this recognition, more attention is being paid to corporate in-house human resource programs. Discussed are the services counselors can bring to industry, such as programs on midcareer stress, retirement, employee assistance, career development, and organizational development. Levels of the consultative relationship are broken down into the following modes: provision of a direct service, prescription of recommendations without intervening, collaboration, and mediation. The consulting process is seen as including the following steps: entry, information-gathering, operational definition of the problem, generation of alternative solutions and their possible consequences, implementation of the strategy, evaluation, and termination.

431. Levinson, H. Consulting with family businesses: What to look for, what to look out for. *Organizational Dynamics*, 12(1):71-80, 1983.

Discusses three kinds of family organizations--family traditional, family conflictful, and entrepreneurial--and the problems and dilemmas faced by consultants for each type. Examples are presented that illustrate the fact that only rarely, perhaps in one incident out of each ten approaches, is a consultation process in a family business consummated. The problems for which consultation is sought are rarely amenable to successful consultative effort. Careful diagnostic assessment is required lest the consultant find him or herself entangled in a complex network of alliances and hostilities.

432. McMahon, B.T., and Spencer, S.A. A systems selling approach to job development. *Journal of Rehabilitation* 45(2):68-70, 1979.

A systems selling approach to rehabilitative job development is described. Using this approach, the job creator assumes a problem-solving posture and seeks to realize a relationship with each employer which is long-term and consultative in nature. Using the systems approach in which the job-ready applicant represents the core product, complementary employer services may include affirmative action assistance to help the employer meet compliance needs; troubled employee assistance to help the employer retain capable employees whose performance is becoming affected by physical or emotional problems; employee compensation assistance; personnel awareness training to aid personnel in accepting and supervising rehabilitants; and maintenance services including ongoing monitoring, evaluation, and improvement of services. The power sources which the job creator must penetrate are presented, together with techniques for dealing with each. (abs.)

433. Morrison, D.E. Psychiatric consultation to management. *Psychiatric Annals* 8(12):47-57, 1978.

The uses and methods of psychiatric consultation to business or government management are described. Differences of viewpoint between manager and psychiatrist may lead to difficulties and must be taken into account. Reasons why managers seek psychiatric consultation are covered, and methods of quickly gaining information about the managers and their business are discussed. Psychiatric consultation to management is described as preventive medicine, with the psychiatrist working with resistances as the leader of a multidisciplinary team. It is suggested that consultation can benefit not only managers of businesses, but companies, hospitals, school districts, or city councils.

434. Munter, P.K. Occupational psychiatry: A one-man program. *Psychiatric Annals* 8(4):38-45, 1978.

A one-man mental health program designed to cultivate a therapeutic alliance between key managers of a 5,000-employee company and a consulting psychiatrist is described. A written proposal stating the purpose, goals, plan, and requirements for the program is included. The importance of the acceptance of the psychiatrist by the management is emphasized. It is concluded that the success of the program depended upon a strong identification with the company by the psychiatrist, and the development of close personal and professional relationships in an atmosphere of trust and mutual respect.

435. Rosen, H., and Stagner, R. Industrial/organizational psychology and unions: A viable relationship? *Professional Psychology* 11(3):477-483, 1980.

The recent gap between industrial/organizational (I/O) psychology and labor unions is examined. It is suggested that the gap is partly attributable to doubt among union leaders that I/O psychologists are truly impartial and partly to a feeling that secrecy is too important for outsiders to be allowed access to collective bargaining data. An important contributing factor is that few graduate programs in I/O psychology give even a mention to union functions. Despite these handicaps, some psychologists have worked successfully with unions, and a modest data bank of useful material on union functioning has been accumulated. It is hoped that union officials will soon come to consult I/O psychologists on organizational problems in a manner comparable to that of management. (abs.)

436. Yeager, J. Managing executive performance: The corporate private practice. *Professional Psychology* 13(4):587-593, 1982.

Discusses how several assumptions in private clinical practice are ineffective in a corporate environment. Many issues affect one's mode of operation: confidentiality, licensing problems in far-flung locations, politics, defining the client, business priorities that determine the choice of clinical goals, relativity of performance criteria, demand for rapid and specific results, degree of business knowledge required, nonclinical interventions, and nonprofit vs. profit priorities. Operating within a corporate framework requires a new perspective before the clinician can have a successful practice within the organizational structure. This is true whether the role is that of an occasional external consultant or an employee of the organization.

See also:

12, 253, 467, 644, 815.

Military Settings

437. Cutting, A.R., and Prosser, F.J. Family oriented mental health consultation to a naval research group. *Social Casework* 60(3):236-242, 1979.

A cooperative effort between a family service agency and a military research and development center to offer counseling to its

employees and their families provides a model for similar partnerships. The program's evolution, the problems encountered and how they are handled, and the future course of such joint ventures are discussed.

438. Jeffer, E.K. Psychiatric evaluations for administrative purposes. *Military Medicine* 144(8):526-528, 1979.

Considerations in psychiatric evaluation for administrative or judicial purposes in the military setting are discussed. While such evaluations are frequently viewed as inappropriate for psychiatric expertise, the utilization of an active consultation model for such evaluations can allow for a positive and productive involvement in the administrative process. Additionally, the development of reporting vehicles which combine the psychiatric and legal vocabularies enhances the consultative role and diminishes misunderstandings and unnecessary adversary confrontations. In the military, administrative evaluation can become the first step in primary prevention consultation. (abs.)

439. Mitchell, G.W., and Orlin, M.B. Service delivery in the military: Training issues. *Social Casework* 61(1):54-57, 1980.

Social work service delivery in the military is described in the context of attempts to improve service delivery through a combination training/consultation model, and typical adjustment problems in the military are described. It is noted that many service personnel find themselves under intolerable pressure and caught between the needs and demands of their dependents and the work demands of the army. Adjustment problems described include adjustment to living in a foreign country, problems of isolation, adjustment problems of young adulthood, alcohol and drug abuse, and marital and family adjustment problems. Organizational misuse of counseling and/or other mental health interventions by the military are described.

440. Raviv, A. Mental health consultation technique as a preventive intervention in a special army base: A program note. *Journal of Community Psychology* 6(4):383, 1978.

The use of consultation sessions for female teachers in the Israeli army who teach recruits with limited education is discussed. It is concluded that the consultations contribute toward increasing the participants' self-confidence and sensitivity to their students, and the students' readiness to discuss their problems. (abs.)

441. Raviv, A. Teachers as caregivers: Mental health consultation in an army base. *Mental Health and Society* 5(3-4):194-199, 1978.

The application of mental health consultation techniques to a special Israeli army framework is discussed. Specifically, female soldiers serving as teachers for a problematic population of male recruits received group consultation from a psychologist assigned to the army reserves. By training the teachers as therapeutic agents or caregivers for the soldiers, it was hoped to achieve greater effectiveness in their work and to reach as many soldiers as possible on an individual basis. These soldiers were taking part in a special enrichment and training program for persons whose illiteracy or emotional difficulties had exempted them in the past from regular army service. The consultation process and subjects raised at group sessions are discussed. (abs.)

442. Rodriguez, A.R. A community mental health approach to military psychiatry. *Military Medicine* 145(10):681-685, 1980.

The application of a community mental health approach to military psychiatry is considered, based on recent developments in theory and changing circumstances that have indicated a need within military psychiatry to redefine the best way to provide more comprehensive mental health services. It is suggested that a community-oriented approach based on multiple services ranging from direct care to consultation, education, supervision, and collaboration will likely be indicated. The following areas are considered: preventive approaches used by a community mental health system, resistance to community psychiatric involvement within the medical system, the community psychiatrist as mental health team coordinator, continuing education of the health professional, the psychiatrist's role in public relations, community education and the psychiatrist, and development of a community psychiatric program.

443. Saidel, D.R., and Begtrup, R.O. Report of a psychiatric consultation service to an army medical clinic. *Military Medicine* 144(9):611-613, 1979.

A psychiatric consultation service to an army medical clinic is described. Despite the existence of a psychiatric outpatient clinic, the new service was well utilized from its initiation. Referrals were made via a patient sign-up sheet used by clinic physicians and paraprofessionals. The population referred was similar to that found in studies with civilian populations. As in such studies, few patients were referred for neurosis. Referrals in order of frequency included psychological symptoms, especially

depression; hypochondriasis; problems in adjustment; somatic illness; medication management; and physician anxiety. Reasons for this pattern of referral are discussed.

444. Shivers, W.F., Jr.; Hulsebus, R.C.; and Havrilla, J.F. A command consultation model for community mental health activities. *Military Medicine* 148(2):159-161, 1983.

This article describes a study of the interaction of the Fort Gordon, Georgia, Community Mental Health Activity and the active duty population at the base over a 3-year period. The Command Consultation Model, which involves regular consultation with unit commanders by the CMHA staff and proximity to troop areas, is discussed.

Minority Settings

445. Delgado, M., and Montalvo, S. Preventive mental health services for Hispanic preschool children. *Children Today* 8(1):6-34, 1979.

A primary prevention community mental health program focused on the needs of Hispanic preschool children is discussed, and the consultation/intervention services provided to the children's parents, daycare teachers, and family daycare providers are described. The needs assessment study which preceded implementation of the consultation program and characteristics of the local Hispanic population are described. It is noted that Hispanic groups are no longer confined to large cities. The increase in demand for services by program staff is discussed in relation to the needs of young Hispanics.

446. Delgado, M., and Scott, J.F. Strategic intervention: A mental health program for the Hispanic community. *Journal of Community Psychology* 7(3):187-197, 1979.

A series of mental health programs developed by the Worcester Youth Guidance Center directed to the Hispanic community of Worcester, Massachusetts, is discussed. The model for these programs has been that of strategic intervention. This approach was based upon knowledge gained from the literature and extensive exploratory contacts with key Hispanic leaders. The Center's Hispanic program consists of five components: (1) community education and training, (2) clinical consultation, (3) program consultation, (4) research, and (5) clinical intervention and case management. Three components are described in detail and rationale for strategic intervention is presented. (abs.)

447. Goodluck, C.T., and Short, D. Working with American Indian parents: A cultural approach. *Social Casework* 61(8):472-475, 1980.

The cultural approach taken by the Jewish Family and Children's Services of Phoenix's Indian Child Welfare Program (ICW) is described. The program is based on the premise that American-Indian children should be placed in Indian homes that reflect as closely as possible their own cultural heritage. During the past 6 years, the ICW has developed into a multiservice program that includes referral and case planning for Indian children, a group home for unmarried pregnant women, adoption services for Indian families, and on-reservation training and consultation of Indian foster parents and staff. The program is considered highly successful because of its understanding of the needs of Indian children, small caseload, and commitment to the goals of the program. Two case examples are presented which illustrate the program's work and highlight its concern with biological fathers.

448. Haven, G.A., Jr., and Imotichey, P.J. Mental health services for American Indians: The USET program. *White Cloud Journal* 1(3):3-5, 1979.

A report on the United Southern and Eastern Tribes (USET) mental health service programs for American-Indians is presented. Fourteen USET mental programs operate in an area which covers virtually the entire eastern half of the United States. The USET program is directed toward community prevention with a major focus on the treatment of alcoholism. Each of the 14 programs is a tribal or Indian group project. Coordination and consultation is provided by the Southeastern Regional Health Board and the Standing Committee on Mental Health and Substance Abuse. USET's approach is to develop human service departments, and workers in the mental health area, who will serve in prevention and treatment of emotional imbalance and behavioral maladjustment without programmatically differentiating mental health, alcoholism, and substance abuse. The status of the individual programs is summarized as to population served and services available.

449. Jilel-Aall, L. Alcohol and the Indian-white relationship: A study of the function of Alcoholics Anonymous among Coast Salish Indians. *Confinia Psychiatrica* 21(4):195-233, 1978.

The close association of Indian alcohol abuse with the Indian-white relationship is reviewed in relation to the Coast Salish tribes, and the nature and functioning of Indian Alcoholics Anonymous (AA) groups are described and related to traditional social

patterns. Coast Salish culture traits are reviewed in relation to their relevance to the sociocultural problems of the Indian population today, and the relationship between patterns of alcohol use and abuse and westernization is explored. It is noted that abstinence from alcohol has been extolled by many religious movements among North American Indians such as the Handsome Lake Religion, the Ghost Dance, the Indian Shaker Church, and the Peyote Cult. It is predicted that only antialcohol programs integrating Indian AA groups with Indian community centers and professional consultation services in an organized effort will have a chance to succeed. (Abs.)

450. Looney, J.; Rahe, R.; Harding, R.; Ward, H.; and Liu, W. Consulting to children in crisis. *Child Psychiatry and Human Development* 10(1):5-14, 1979.

The efforts of a mental health consultation team to meet the needs of a large population of children under acute stress are described. On the basis of study of children and adolescents living in an American camp for Vietnamese refugees, recommendations accentuating the positive factors of the environment while offsetting the negative and potentially deleterious factors were made. In the area of primary prevention, recommendations called for provision of clothing and recreational opportunities, establishment of infant care preschool programs, provision of preventive medical care, encouragement of interaction between refugees and Marines, establishment of meaningful work within the camp, utilization of indigenous leaders, provision of facilities for religious practice, and quick placement and followup services for families. Further recommendations for secondary prevention are also presented.

451. Rahe, R.H.; Looney, J.G.; Ward, H.W.; Tung, T.M.; and Liu, W.T. Psychiatric consultation in a Vietnamese refugee camp. *American Journal of Psychiatry* 135(2):185-190, 1978.

The authors provided psychiatric consultation to medical personnel in charge of a Vietnamese refugee camp in California. Although the emergency measures that supplied clothing, food, shelter, and medical care to nearly 60,000 refugees were immensely successful, consultation was requested to assist with selected mental health problems. The recommendations of the consulting team were related to the stage of camp development: early recommendations concerned easing adaptation to the camp setting; later efforts included creating a psychiatric crisis clinic and carrying out a mental health survey on a random sample of refugees. The results of this survey helped camp directors to understand how refugees responded to the camp experience.

452. Scott, J.F., and Delgado, M. Planning mental health programs for Hispanic communities. *Social Casework: Journal of Contemporary Social Work* 60(8):451-456, 1979.

Issues, developmental stages, and administrative decisions involved in planning mental health programs for Hispanic communities are discussed within the context of program planning in Worcester, Massachusetts. The Worcester program included community education and training, clinical and program consultation, research, and clinical intervention and case management. Phases of development include the initial phase during which funds were obtained, needs assessment and planning phase, and staff hiring and implementation. Administrative problems in gaining acceptance, needs assessment, staff recruitment, and coordination with the community are discussed. The need for awareness of the influence of cultural factors on service delivery is noted.

See also:

31.

Religious Settings

453. Slaikeu, K.A., and Duffy, M. Mental health consultation with campus ministers: A pilot program. *Professional Psychology* 10(3):338-346, 1979.

A 1-year mental health consultation program with campus ministers at a large southwestern State university is reported. A weekly 2-hour group format was used. Over the course of the year, time was devoted to didactic presentations on crisis intervention, assertiveness training, human sexuality, marriage counseling, and group dynamics. Additional attention focused on case consultation, intensive individual supervision, and group problem solving with extensive use of modeling, role play, and feedback. Strategies used by the group and its leaders in dealing with the issues raised and unique aspects of the counseling role of ministers are discussed. (abs.)

See also:

274, 281, 711, 770.

Social Agencies

454. Feldman, Y. The early history of modern psychoanalysis. *Modern Psychoanalysis* 3(1):15-27, 1978.

The experiences of a group of social workers at the Jewish Board of Guardians while they were in training to understand and treat borderline psychotic children and their parents are described. Case histories illustrate how the groups trained by Dr. Sponitz, who led the project from 1944 to 1954, began to analyze treatment interviews to identify resistance and how children originally diagnosed as easy cases were found to be seriously disturbed. Under the impact of Dr. Sponitz's training, supervisors were able to convey to workers the notion that client's expressions of negative feelings toward the workers were therapeutic, and that they could learn how to respond correctly to messages conveyed in such verbal attacks. In regular conferences with the consulting psychiatrist the case workers came to understand, resolve, and master (1) the emotional problems induced in the worker by the client; (2) the emotional problems of the client; and (3) the strategy involved in resolving the emotional problems of the client.

455. Grindrod, N. Fostering: A pan London approach. *Social Work Today* 10(8):11-13, 1978.

The development of a joint effort on the part of London foster care agencies is described. Over the course of 3 years, adjacent foster care officials recognized their common concerns, their need for one another's consultation and advice, and the unnecessary duplication of services. Funding arrangements and publicity campaign approaches are outlined. The improvement of professional practices, fostering exchanges, existing regulations, training, and standardization of fostering practices are under review. It is concluded that the joint approach of London foster care agencies will work to improve the level of care available, that foster care is superior to residential care, and that the concentrated publicity campaign is highly effective in convincing parents to volunteer for foster care.

456. Jones, M.L. Finding permanent homes for children in foster care: A do-it-yourself approach. *Children Today* 8(2):8-36, 1979.

The characteristics of an aggressive program for finding permanent homes for children in foster care are described using data obtained in a rural Pennsylvania county program. The county invested less than \$100 in goal planning training materials, adapting some that were developed for mental health workers for use in child welfare. Basically, workers are taught that the goal

for children is a permanent, stable home and that work with families should be directed toward achieving that goal. Shortening the length of foster care by returning the child to natural parents or completing the adoption process has made the system a much more stable and less expensive program. The keys to program success are seen as the strong agency leadership, extensive training for caseworkers, and provision of consultation to staff members.

457. Jones, M.L., and Biesecker, J.L. Training in permanency planning: Using what is known. *Child Welfare* 59(8):481-489, 1980.

Following a review of factors associated with greater permanency of foster care placement of children, the Training Resources in Permanency Planning (TRIPP) program is described. Factors found to be associated with reduced foster care drift included leadership, regular review of children in care, goal-oriented casework, and consultation and technical assistance. TRIPP sought to develop simple, usable, and inexpensive training materials for use by local child welfare agencies in achieving permanency planning for children in care. To this end, three training manuals dealing with goal and permanency planning in child and youth services were developed and tested in 60 workers and supervisors of eight county child welfare services. In Phase 1, subjects were trained in goal planning strategies emphasizing permanency. Phase 2 involved training in the assessment of placement options, provision of replacement services, and statutes and procedures relating to adoption. In Phase 3, consultation was made available to subjects who recounted their experiences with goal and permanency planning. Comparison with data for control agencies indicated that TRIPP subjects showed fewer emergencies, achieved more goals and set more permanent plans, and showed greater confidence in outcome predictions.

458. LeBlang, T.R. The family stress consultation team: An Illinois approach to protective services. *Child Welfare* 58(9):597-604, 1979.

The family stress consultation team, an experimental, multidisciplinary approach to the handling of child abuse and neglect cases, is described. The community-based volunteer consultation group is used by the Illinois Department of Children and Family Services (DCFS) as a voluntary agency under the Illinois Abused and Neglected Child Reporting Act. The team accepts referrals from the DCFS and provides multidisciplinary consultation to offer a coordinated evaluation and comprehensive plan of management in selected abuse and neglect cases. Team services are voluntary (except for those of the team coordinator) and aim to

protect the child and the child's caretakers and to stabilize the home environment whenever possible.

See also:

24, 131, 145, 241, 306, 521, 637, 722, 802.

The Process of Mental Health Consultation

Aspects of Process in General

459. Bayes, M., and Newton, P.M. Women in authority: A sociopsychological analysis. *Journal of Applied Behavioral Science* 14(1):7-20, 1978.

Issues related to authority and sex roles are raised in a sociopsychological analysis of the case of a woman chief of a community consultation unit in a mental health center. Based on an examination of traditional roles, it is suggested that, because of the fantasy and fear of women's (mothers') power, both men and women are socialized to accept a stereotype of women as possessing legitimate authority only to nurture. It is therefore difficult for a woman to exercise authority in areas seen as inappropriate to her sex role and for which she receives little or no early training: maintenance of a group's external boundary, mobilization of aggression in the service of work, and establishment of a "number 2" position to her leadership position. She is also likely to stimulate and collude in the maintenance of dependency in her staff. In the case described, the woman unit chief was continually undercut and disregarded by her staff and others, and she was unaware of how to handle these problems. It is concluded that a woman in authority must be prepared to counteract strong social forces in herself and in others that act to preclude competent leadership behavior. (abs.)

460. Christian, W.P. Managing the performance of the human service consultant. *Behavior Therapist* 6(3):47-49, 1983.

Argues that human service programs typically make neither adequate nor effective use of outside consultants (Cs). If the C's performance is to be maximally productive and efficient, it must be focused: Cs must understand the goals and objectives of their employment and the product that is expected (e.g., written vs. verbal feedback). Strategies for selecting a C, managing C performance, and maximizing C effectiveness are discussed.

461. Davis, J.M., and Sandoval, J. Metaphor in group mental health consultation. *Journal of Community Psychology* 6(4):374-382, 1978.

The concept of the metaphor and the construction of metaphors by group members are reviewed, and a set of cues is given to help consultants identify the existence of a metaphor. Various functions the metaphor can play in group and individual unconscious and preconscious thinking are also discussed. Four general strategies for responding to a metaphor are outlined and evaluated, and examples of the metaphor in a group mental health consultation are provided. (abs.)

462. DeGiovanni, I.S.; Gordon, M.E.; and Schlesinger, S.E. Beyond outcomes: Evaluating staff functioning on an inpatient psychiatric ward. *Journal of Psychiatric Nursing and Mental Health Services* 16(4):28-31, 1978.

Theoretical issues and methodology for evaluating staff functioning are presented in the context of an evaluation of a 30-bed inpatient psychiatric ward. The staff evaluation process is divided into four stages. The first phase is that of entry and attachment and is characterized by the attempts of the evaluator to establish his or her role within the program, to clarify the objective of the evaluation, and to identify the constraints upon the evaluation. In the second phase, the evaluator chooses or develops valid measuring instruments and seeks to administer them in ways that are compatible with the process being measured. The third phase consists of data analysis and report writing. The final phase concerns the feedback of evaluation results and the termination of the consultation.

463. Flanagan, S.G.; Cray, M.E.; and Van Meter, D. A facility-wide consultation and training team as a catalyst in promoting institutional change. *Analysis and Intervention in Developmental Disabilities* 3(2-3):151-169, 1983.

Staff training in behavior modification (BM) and large-scale program development at Camarillo State Hospital were facilitated by a mobile consultation and training team (CTT). Working closely with top management, the team trained staff and developed services "on the job" in the residential units. Staff acquisition of BM skills was necessary but not sufficient for program delivery. Management practices promoting utilization of clinical skills and maintenance of programs were essential. Discussion focuses on the entry process at multiple levels in the organization, the use of active and directive training methods to achieve skill-oriented goals, multilevel evaluation of training planning for maintenance, and social/political issues in "institutionalizing"

positive changes. In the 7 years since the establishment of the CTT, significant progress has been made toward institutionalizing behavior modification technology. Administrators and direct service staff are generally cognizant of and oriented toward behavioral treatment approaches. On-line staff are better skilled in conducting behavioral treatments. On a large scale assessment of basic BM skills, CTT-trained staff performed significantly better than the facility-wide average.

464. Nufrio, P.M. Diary of a mad internal consultant. *Group and Organization Studies* 8(1):7-14, 1983.

The author discusses eight factors that contributed to his development and learning as an internal consultant: (1) making psychological contracting an integral part and ongoing process of the consultant's role, (2) ensuring that preentry diagnosis is conducted properly, (3) understanding the pitfalls of team consultation, (4) properly introducing the internal consultant to the clients, (5) having confidence in one's own intervention philosophy, (6) maintaining objectivity and avoiding overidentification with client and problems, (7) placing role multiplicity into perspective, and (8) understanding which levels of inclusion with clients help and hinder the consultant-client relationship. The author's "diary" may serve as a reminder of the pitfalls facing internal consultants and help save them from such maddening experiences.

465. Pfeiffer, S.I. The school-based interprofessional team: Recurring problems and some solutions. *Journal of School Psychology* 18(4):388-394, 1980.

Suggests that the interprofessional child study team can provide greater accuracy in decisionmaking and a creative extension of psychoeducational services to the school. Four problem areas presently interfere with most teams' effective functioning: minimal parental and regular educator involvement, unsystematic collection and analysis of the diagnostic information, a loosely construed decisionmaking/planning process, and a lack of interdisciplinary collaboration. Strategies are suggested to promote team effectiveness.

466. Ronning, J.A., and Thorsen, S.A. Procedures for establishing generalization and maintenance of treatment effects: III. Integrating procedures for generalization and maintenance in a consultative model. *Scandinavian Journal of Behaviour Therapy* 10(1):3-20, 1981.

Argues that aspects of operant and cognitive procedures for establishing and maintaining treatment gains can be integrated in the consultation model originally developed by Tharp and Wetzel

(1969). On the basis of empirical research, however, it would be premature to conclude that consultation will produce long-term and generalized behavior changes. The article discusses presumptions that seem essential to promote generalization and maintenance within a consultative approach. The authors argue for a systematic analysis of the qualitative aspects of the relations involved in the consultative triad to be used as the base for developing an intervention. It is concluded that procedures for generalization and maintenance of the mediator's behavior should be an integrated part of the consultant's work with the mediators.

467. Sims, D., and Jones, S. Explicit problem modeling: An intervention strategy. *Group and Organization Studies* 6(4):486-499, 1981.

Discusses how organization development (OD) consultants could employ more explicit representations of the problems that they work on with client teams. The problems that organizational team members define depend on their idiosyncratic, subjective, and organizational political beliefs. Eight reasons that discourage OD consultants from making problem definitions explicit are simplification, quantification, objectivity, expectation offenses, tedium, awareness of conflict and power, demystification, and lack of explication skills. The particular problems of working with a client team, rather than an individual, are discussed. An example is presented in which consultants helped a magazine publishing team plan for the future by distinguishing ideas and beliefs as dichotomous descriptions, increasing or decreasing conceptualizations, or relationships.

468. Talbott, J.A. The elements of community consultation. *Psychiatric Quarterly* 49(4):273-290, 1979.

Consultation to community agencies and institutions is an active and exacting art. A case example is presented that outlines several phases in a consultation to an urban police department performed by a division of community psychiatry over a 6-year period. Seventeen elements of a consultation are discussed: choice of consultation, entry, organizational structure, familiarization and testing, the contract, phases of consultations, information gathering, diagnostic evaluation, information giving, mutual assessment and action plans, types of consultations, formats, resistances, attitudinal problems of the consultant, evaluation, exit problems, and funding.

469. Whitman, R.M., and Morgan, H.E. Group process during a consultation: An institution copes with perceived homosexual onslaught. *Social Psychiatry* 16(2):105-109, 1981.

Illustrates how the consultative process may use group interventions to lead to an institutional solution of a longstanding problem via the mobilization of the consultees themselves in a concerted effort. The concerted effort in this example related to the loss of autonomy and territory by a school of education to homosexuals who pursued a particular lifestyle within that school of education. The consultative group process itself paralleled the successful institutional coping device of shared assertiveness.

470. Wilson, H.S., and Underwood, P.R. A consultative analysis of learned helplessness at "city hospital." *Perspective Psychiatric Care* 18(6):256-260, 1980.

It is known variously as "reality shock," bureaucratic-professional conflict, institutionalization, and even oppression. Whatever one calls it, however, the phenomenon described and conceptualized as "learned helplessness" by nurse-author Karen Malcomson is a vexing, trying, and familiar one to any clinician who has attempted to bring about change in a complex institution.

471. Wollert, R.W.; Knight, B.; and Levy, L.H. Make today count: A collaborative model for professionals and self-help groups. *Professional Psychology* 11(1):130-138, 1980.

Collaboration between self-help groups and mental health professionals is discussed. Obstacles that thus far have prevented such a collaboration include the lack of published reports on successful collaboration and the lack of an adequate model for the establishment of positive working relationships. A field study in which members of a self-help research team provided services of significant impact to one chapter of Make Today Count is presented. A collaborative model is formulated with important elements such as adequate knowledge of self-help processes, enhancement of rapport through acceptance of the group, and adoption of a consultative approach. The present results are contrasted with negative results reported previously by professionals who attempted to collaborate with a similar self-help population, but who applied a different model. (abs.)

See also:

6, 8, 11, 12, 13, 24, 28, 31, 35, 36, 37, 105, 252, 280, 288, 319, 329, 333, 356, 374, 381, 383, 430, 506, 554, 587, 620, 715, 742, 756, 796, 810, 830.

Training of Mental Health Consultants

472. Agbayewa, M.O., and Perez, E. Consultation liaison training in Canadian psychiatric residency programs. *Canadian Journal of Psychiatry* 27(6):484-485, 1982.

Canadian psychiatry residency programs were surveyed through questionnaires to determine the status of consultation liaison training (CLT) for the year 1979-80. Virtually all the programs offered CLT as lecture/seminars and clinical postings. The majority of residents who received CLT were in their first and second years, with the average trainee spending less than 6 percent of total clinical training time in consultation liaison work. About 9 percent of the total teaching time was devoted to consultation liaison psychiatry (CLP) and related topics. Canadian medical students are exposed to CLP in various forms during their training. There is little interdisciplinary collaboration or post-residency fellowship in CLP at this time. The authors suggest that CLT be offered in the last 2 years of training when the trainee can be an effective consultant with a consolidated identity as physician and psychiatrist. They also recommend an increase in interdepartmental collaboration and further development of post-residency fellowships in consultation liaison psychiatry.

473. Alpert, J.L.; Silverstein, J.M.; and Haynes, R. Utilization of groups in training for school consultation. *Journal of School Psychology* 18(3):240-246, 1980.

The use of groups during the past 6 years in a 2-semester school consultation practicum course is described, as are problems and issues raised by user groups. During the course of the groups, the following three tensions arise: (1) whether groups should focus on process or content, (2) whether the instructor's role in the group is supervisory or consultive, and (3) whether the format should be structured. The following topics are briefly introduced: consultation as a mental health service to schools, the value of groups in consultation training, and the course offered in school consultation. (abs.)

474. Bergan, J.R.; Kratochwill, T.R.; and Luiten, J. Competency-based training in behavioral consultation. *Journal of School Psychology* 18(2):91-97, 1980.

The competency based (CB) approach to training and evaluation of prospective school psychologists in behavioral consultation is described as it has been used at the University of Arizona. The design of CB consultation training involved three steps: establishment of specific training objectives; development of training

procedures related to these objectives; and development of evaluation procedures to determine the extent to which training objectives have been achieved. Major training objectives include both acquisition of factual knowledge related to consultation research strategies and methodological tools, and the development of such consultation skills as problem identification and analysis, problem solving, interviewing processes and communication skills, and outcome assessment. Training procedures to meet these objectives include lectures, discussions, reading assignments, role playing, and supervised consultation experiences. Evaluation provides feedback for determining skills mastery and additional training needs. The benefits of a CB training approach are noted. (abs.)

475. Blumenthal, M.D.; Davie, J.W.; and Morycz, R.K. Developing a curriculum in psychogeriatrics. *American Journal of Psychiatry* 136(9):1157-1161, 1979.

A curriculum designed to train geriatric psychiatrists is described. For the geriatric psychiatric patient, drug interaction, drug-disease interactions, and multiple illnesses are often serious problems. Support and simplification of the regimen are often crucial elements in the maintenance of these patients, and it is often most practical and desirable that the psychiatrist become the primary care physician. Such a role requires understanding of the patient's medical, social, and psychological state, as well as his or her psychiatric condition. The training of geriatric psychiatrists toward the goal of such understanding is described, focusing on differential diagnosis and treatment, pharmacologic issues, consultation, community resources, and psychiatric, medical, and psychosocial aspects of care. (abs.)

476. Brown, D.K., Jr. A package program to teach behavioral consultation interview: An analogue study. *Dissertation Abstracts International* 41(2):590-A, 1980.

An instructional package is presented for training preintern psychologists in behavioral interviewing techniques. A specific interview format, the problem identification interview, was combined with microsetting technology to provide an efficient method of training consultation verbal skills. When the instructional package was evaluated with a multiple baseline across subjects design, results indicated that verbal skills specific to the interviewing format were acquired and maintained across several experimental sessions and at a 2-month followup. A social validation questionnaire is reported to reveal that subjects of the study found the training to be preferable to traditional methods and relevant to future applied practice. (abs.)

477. Brown, S.W. Competency-based objectives for training in clinical psychology. *JSAS/Catalog of Selected Documents in Psychology* (APA) 9:21, 1979.

A set of competency-based objectives for the training of clinical psychologists at the California School of Professional Psychology is presented. These objectives are observable and measurable behaviors that are seen as some of the relevant dimensions of clinical competence. As applied in a training institution, competency-based objectives are the minimum knowledge and skill standards that all students are required to meet in order to complete training. Since competency-based objectives reflect relevant aspects of clinical practice, their use in an educational program can facilitate relevant instruction while simultaneously monitoring and assessing both the results of the instruction and the competency of the graduates. The objectives can also help minimize ambiguity in the educational system. Competency-based objectives are identified in five major areas: (1) clinical assessment and referral; (2) psychotherapy; (3) research and evaluation; (4) supervision, consultation, and teaching; and (5) professional ethics. (abs.)

478. Carr, R.A. A model for consultation training in Canadian counselor education programs. *Canadian Counselor* 15(2):83-92, 1981.

The consultation role has been proposed as a way for counselors to improve their service, focus on student growth and development, and be accountable. Role modeling, research activities, direct-service orientations, conceptual problems, and the lack of training models are discussed in terms of barriers to the advancement of consultation training. Recommendations are presented for a model that emphasizes specialized training for persons to become consultants to counselors. (abs.)

479. Cochran, D.J. Contracting in consultation: Training guidelines and examples. *Counselor Education and Supervision* 20(2):125-131, 1980.

Training guidelines for contracting in consultation are presented and exemplified in a response to proposed expansion of the counselor role to that of behavioral scientist, deliverer of indirect services, and consultant. An operational definition of contracting, a component consultation skill, is provided. The purposes of contracting are reviewed as a means to mark the progress through various phases of the consultation, as a tool for defining the nature of the consultation relationship, and to educate the consultee in the modes of consultation to be considered. A contract

should specify short-range objectives and long-range goals, the roles of the consultant and the consultee and the processes involved, and a time frame for planned procedures and outcomes. The contact should also include any evaluation methods agreed upon. Implications for use are also considered. (abs.)

480. Cohen, G.D.; O'Brien, J.J.; Gillilan, J.V.; Walsh, T.L.; and Anthony, R. Geriatric psychiatry training: A brief rotation. *American Journal of Psychiatry* 137(3):297-300, 1980.

Following a review of general considerations in geriatric psychiatry training, a brief clinical rotation for working with the elderly implemented by the Georgetown University Department of Psychiatry is described. The goal of the rotation was to facilitate a diversity of clinical experience through a familiarity with older persons and patients; experience with a team approach to treatment; awareness of the interplay of medical, psychiatric, and social factors; and experience with consultation as well as direct care. The didactic component of the rotation involves weekly supervision meeting with a focus on clinical experiences as related to issues in aging, biometrics, assessment and diagnosis, treatment approaches, and services and settings. Each resident actively follows 12 to 17 patients in direct care and about half this number through consultation. The brief rotation provides an effective method for improving one's approach to the elderly within a limited time. The clinical rotation enables the resident to learn more about psychiatric issues in later life, as well as to acquire a better perspective on other parts of the life cycle and other aspects of psychiatry. (abs.)

481. Cohen-Cole, S.A.; Haggerty, J.; and Raft, D. Objectives for residents in consultation psychiatry: Recommendations of a task force. *Psychosomatics* 23(7):699-703, 1982.

Describes the work of the Association for Academic Psychiatry Task Force on Consultation/Liaison Objectives and discusses the principles behind the development of a proposed set of training objectives for residents in consultation psychiatry. These proposed objectives are presented in their complete form, followed by an elaboration of the knowledge objectives concerning the consultation process.

482. Errek, H.K., and Randolph, D.L. Effects of discussion and role-play activities in the acquisition of consultant interview skills. *Journal of Counseling Psychology* 29(3):304-308, 1982.

Fifteen graduate students in each of two experimental groups were enrolled in a consultation course in which they received a didactic explanation and viewed a videotaped demonstration of consultant interview skills. Students in the first experimental group participated in role play practice activities; students in the second experiment group participated in discussion activities. Fifteen graduate students not enrolled in the course comprised a third group, and they received no training. Interview skills of all groups were assessed by rating students' oral responses to simulated videotaped consultation interview segments. Results indicate that students in the role play group made a significantly higher mean number of appropriate responses than students in either the discussion or control group. No significant differences were found between students in the role play and discussion groups on degree of satisfaction with the course.

483. Gabinet, L., and Schubert, D.S. Teaching hospital inpatient consultation-liaison to psychology trainees and interns. *Teaching of Psychology* 8(2):85-88, 1981.

Delineates the strengths and weaknesses that psychology interns bring to their work on the consultation-liaison (C-L) rotation in a medical setting. Some topics discussed are the intern's facility in dealing with psychological and biomedical data, communication with the hospital staff, approaching patients, differential diagnosis, and psychotropic medication. It is felt that consultation services in hospitals are in great demand and that psychologists trained in C-L can augment available mental health services.

484. Gallessich, J., and Ladogana, A. Consultation training program for school counselors. *Counselor Education and Supervision* 18(2):100-108, 1973.

In order to increase counselors' effectiveness in cooperative and system approaches to problem solving, a large school district offered an in-service consultation program. Two successive training designs were piloted and evaluated. Evaluation of the first training model led to a shortened, revised model that was more efficient and as highly rated by counselor trainees as the earlier, lengthier model. This training program was associated with significant increases in counselor collaboration with faculty and staff. Several recommendations are proposed for further improvements in the training design.

485. Granet, R.B.; Perry, S.W. III; and Talbott, J.A. A resident's rotation in consultation psychiatry: A maturational experience. *General Hospital Psychiatry* 2(4):306-309, 1980.

The authors emphasize the importance of a consultation psychiatry experience in the maturation of the young psychiatrist by examining some of the processes operational in both community and hospital consultation work, performed by the senior author during his fourth year of residency. Such experiences can provide opportunities for developing psychiatric skills not emphasized elsewhere, including the adoption of an active therapeutic stance, the application of the psychodynamic theory to the consultation system itself, and teaching without the use of jargon. In addition the experience as consultant facilitates the transition from residency to the outside world, not only through attitudinal changes achieved by exposure to less structured settings, a change in the supervisory model, and a solidification of identity as a physician and psychiatrist, but also by providing the resident the opportunity to begin de-cathecting from the training program.

486. Guggenheim, F.G. Contributions in teaching consultation-liaison psychiatry. The use of the medical team model on a consultation-liaison teaching service. *General Hospital Psychiatry* 4(3):219-224, 1982.

This paper describes a consultation liaison (C/L) teaching service that uses a medical team rounding model; four teams cover distinct geographic areas of the hospital, each team consisting of an attending psychiatrist, a resident, two medical students, and a psychology graduate student. Daily attending rounds on the medical/surgical wards provides prompt and direct patient care supervision for the team members, allowing for coordination of their activities and communication with the attending physician, who serves as a role model. Psychological testing can be readily integrated into the clinical setting; neurology and family practice residents can also get their psychiatric training in this setting. The medical team model of rounding is different from other models used on C/L services; its pros and cons are discussed.

487. Idol-Maestas, L. A teacher training model: The resource/consulting teacher. *Behavioral Disorders* 6(2):108-121, 1981.

Describes a model for the training of a resource/consulting teacher (R/CT) at the University of Illinois. R/CTs provide direct, data-based instruction in resource settings, with intent to return students to regular classes. R/CTs share observation, student management, and recording skills through an applied

behavior analysis framework. Examples of data-based consultation projects that have been implemented by R/CTs in collaboration with regular class teachers are included.

488. Kantor, S.J.; Chiarandini, I.; and Heller, S.S. The use of the psychiatric consultation record for residency training. *General Hospital Psychiatry* 1(3):202-213, 1979.

The use of the Psychiatric Consultation Record (PCR) as an aid to teaching consultation psychiatry, to evaluate the impact of this teaching, and to provide an overall assessment of consultation training programs is described. The PCR both structures the resident's training experience and provides a tool with which he or she can integrate theoretical and practical knowledge pertaining to consultation work. Its use has enabled supervisors to detect the degree to which didactic material has become integrated into residents' thinking and has provided data through which the scope and quality of each resident's work can be rapidly assessed. Finally, its use has brought to light deficiencies in service delivery which had not been apparent. (abs.)

489. LaMotte, K.J. Usefulness of training components of a clinical psychology internship program from the perspective of current employment. *Clinical Psychologist* 33(2):23, 1980.

In a followup study, aspects of the UCLA Neuropsychiatric Institute Clinical Psychology internship viewed as most and least useful in current employment were examined in questionnaire responses of 34 (77 percent return rate) interns who graduated between 1971 and 1975. The majority of respondents spent over half their time in clinical practice. Respondents rated their internship as excellent (77 percent) or good (23 percent), with academically employed respondents more likely to give an excellent rating. For all respondents, experiences concerned with patient treatment were viewed as most useful. Differences were found in ratings of various aspects of training depending on respondents' academic or clinical employment status. Clinicians expressed the need for additional training in administration, research, and teaching, while academics expressed training needs in the areas of research and teaching skills and felt the need for some support in administration and community consultation skills.

490. Levy, N.B. The teaching of liaison psychiatry in the hemodialysis center. *Bibliography Psychiatry* 159:141-144, 1979.

The hemodialysis unit is usually a uniquely desirable place for liaison teaching because of the importance and variety of

behavioral problems seen there. The trainee may be educated at these units about the syndrome of delirium because of the potential for seeing in a given patient the presentation and resolution of the syndrome before and after each run. Because of the abject dependency of these patients, issues surrounding patient dependency "needs" and frustration of their independence are common with patient "uncooperativeness," an important area in which the professional staff need education and patients need intervention. Depression, common among these patients because of their many losses, is among the host of psychological problems to be potentially diagnosed and treated by the liaison trainee and/or teacher. The theme of life setting conducive to medical illness and the setting of realistic rehabilitation goals are also important areas of liaison training, particularly suitable for demonstration there. Therefore, hemodialysis centers offer usual wide variety and often untapped resources for liaison education.

491. Maiuro, R.D., and Trupin, E.W. Rural internships: Fixed role therapy for the community mental health professional. *Hospital and Community Psychiatry* 31(7):497-499, 1980.

Observations are reported from a rural internship program designed to train community mental health professionals using fixed role therapy. The program includes experiences specifically designed to develop a wide range of skills beyond traditional psychodiagnostic and psychotherapeutic strategies. These skills relate to such areas as community consultation, outreach programming, crisis intervention, and community organization. The principle of fixed role therapy uses a learning environment to break up constricted ideas about professional role and identity. This procedure calls for the therapist to construct a role sketch that provides a script of the behavioral tasks the client is to enact; as a result the trainee is aided in developing the necessary skills and identity.

492. Peebles, M.J., and O'Malley, F. Problems in mental health consultation facing the professional in training. *Journal of Clinical Child Psychology* 7(1):68-70, 1978.

Unique factors characterizing mental health consultation training and subsequent problems which arise are discussed from the trainee's point of view. These factors include consultation contracts, consultant selection, remuneration, experience level, and tenure. Suggestions are offered to ameliorate problems arising from these factors. (abs.)

493. Plutzer, M.D. The elective within the required psychiatric clerkship. *American Journal of Psychiatry* 136(5):706-708, 1979.

An elective program within the required medical school psychiatric clerkship that meets two important goals of a successful psychiatric clerkship is outlined. The two goals are to maximize students' responsibility and flexibility and to provide knowledge and skills relevant to their future careers. The basic 6-week program involves students assuming varying amounts of responsibility for patient care with intensive experience on an acute medical college hospital ward, a more intermediate care State hospital ward, or as part of the liaison consultation team. Additional requirements and electives are described. On the basis of feedback from both students and staff, it is concluded that the advantages of the elective program to students, patients, faculty, and the department far outweigh the disadvantages. (abs.)

494. Pruitt, A.S. Preparation of student development specialists during the 1980s. *Counselor Education and Supervision* 18(3):190-198, 1979.

Issues and recommendations for the preparation of student development specialists are discussed. Opinions regarding research, curriculum, and competency-based instruction needs are expressed, and it is argued that one way of strengthening instruction is through implementation of a common core of studies. The American College Personnel Association has proposed six competencies for inclusion in the skills portfolio of student development specialists: goal setting, instruction, assessment, consultation, milieu management, and evaluation. It is concluded that training must continue to be responsive to changes in students, to changes in the role and function of practitioners, to changes in society, and to changes in the art of education for the helping professions. (abs.)

495. Randolph, D. Teaching consultation for mental health and educational settings. *Counselor Education and Supervision* 20(2):117-124, 1980.

A practical model for teaching consultation skills to graduate students of counseling or counseling psychology in training for employment in mental health or educational settings is described. The model consists of two phases: didactic presentation and demonstrations of consultation theory and processes; and student projects involving simulations of individual and group consultations, which are taped and evaluated. Preliminary results of studies, including employer evaluations of course graduates, support the above training model. To date, the model has been

employed successfully for both preservice and inservice training of professionals in consultation skills. (abs.)

496. Reifler, B., and Eaton, J.S., Jr. The evaluation of teaching and learning by psychiatric consultation and liaison training programs. *Psychosomatic Medicine* 40(2):99-106, 1978.

The evaluation components of 50 applications for NIMH funding in psychiatric consultation and liaison training programs were assessed, and evaluation techniques are reviewed. In assessment of evaluation components, particular emphasis was placed on the interdependence of goals and objectives, curriculum, and evaluation procedures. Results indicate that all 50 programs identified goals and/or objectives ranging from simple and broad one- or two-sentence goal statements to more sophisticated and specific objectives. Only 12 programs specified definite behavioral objectives. Curricular content for psychiatric residents generally included supervised consultation or liaison, provision of consultation on trainees' patients (residents only), didactic seminars, and case conferences. Evaluation techniques reported include videotaped interviews, knowledge examination, chart audits, attitude ratings, and career followup. The importance of an interrelationship among these three components is emphasized.

497. Russ, S.W. Training child mental health consultants. *Journal of Clinical Child Psychology* 7(1):65-67, 1978.

Essential elements of training programs for child mental health consultation are discussed. These areas are theoretical foundation in consultation, techniques of consultation, traditional clinical psychology, clinical child psychology, and program evaluation. It is asserted that consultation skills must be built upon supervised experiences. Consultation settings must be carefully chosen to match the level of experience of the consultant. (abs.)

498. Schechter, N.L., and Levine, M.D. School health training for the practicing physician. *Journal of School Health* 50(6):347-351, 1980.

An affiliation between a major medical center and a public school system which provided a training site for practicing physicians is described. An attempt was made to diminish the adversarial flavor of many physician-educator interactions by making physicians more comfortable in the school setting by demystifying educational jargon, demonstrating basic developmental concepts, and revealing the gamut of potential educational interventions for children with developmental handicaps. Program components included didactic presentations by the special educator, relating

the elementary school experience and materials to normal school age development; classroom visitation; and interactive consultation between physician and educator. The evaluation process and consultation outcome of children referred to the program are outlined in tabular form. Finally, guidelines for the development and implementation of similar programs are provided. (abs.)

499. Schubert, D.S. Teaching psychiatry to medical students on a consultation service. *International Journal of Social Psychiatry* 23(4):282-284, 1977.

Medical students experience psychiatric consultation as part of their undergraduate psychiatric clerkship experience. This allows further identification of the medical student with the psychiatrist in management of psychiatric problems in patients who are primarily nonpsychiatric. Reaction from the medical students has tended to be favorable without a great loss of speed or efficiency in terms of the service commitment.

500. Schwartz, S., and Tuma, J.M. Graduate training in consultation and liaison. *Journal of Clinical Child Psychology* 7(1):47-49, 1978.

The findings of a survey of all graduate programs in psychology conducted to determine the types of training available in consultation and liaison are reported. While graduate programs not approved by the American Psychological Association (APA) place more relative emphasis on training in consultation than do APA-approved programs, the latter provide a greater range of practicum experiences than the former, which tend to rely more on courses and seminars. The larger number of students typically enrolled in non-APA programs are not generally compensated for by larger numbers of supervisors, suggesting that their supervised experience in consultation is less intense than that of students enrolled in APA-approved programs. Nevertheless, nearly twice as many graduate of non-APA-approved programs accept positions in which consultation and liaison are important parts of their duties than do graduates of APA-approved programs. (abs.)

501. Shore, J.H.; Kinzie, J.D.; and Bloom, J.D. Required educational objectives in community psychiatry. *American Journal of Psychiatry* 136(2):193-195, 1979.

Formal educational objectives in community psychiatry developed for a University of Oregon training program are presented. The community psychiatry training program is a half-time, 6-month experience in the third postgraduate year, plus a 6-month, fourth-year elective. The curriculum includes all activities of indirect services that would be performed by a psychiatrist in a community

setting, including consultation, interdisciplinary team participation, administration, community educational tasks, supervision of coprofessionals, and forensic psychiatry. Specific theoretical and clinical objectives to be met by trainees are detailed. Field experience, supervision, and seminars are designed to meet these objectives. Evaluation includes supervisory reports and oral and written examinations.

502. Sklare-Lancaster, A., and James, J.S. A group counseling training model: The Detroit project. *Journal for Specialists in Group Work* 3(3):154-159, 1978.

A training program designed to give public school counselors experience and training in group counseling is described. Three phases of this program to introduce personal mastery concepts to counselors, for their own personal use and for use in group counseling sessions with students, are identified. Three hundred counselors were given the first phase of 30 hours of training. Fifty of these were selected to participate in the second 30-hour phase, which prepared them to lead groups in conjunction with other counselors in their own schools; and 25 were selected to attend the third phase, which concentrated on developing supervisory skills to provide further training and consultation services for other counselors in the school system. While the results of formal evaluation efforts are not yet available, it is concluded that the reactions of participants in this training program have been overwhelmingly positive.

503. Solomon, S.; Saravay, S.M.; and Steinberg, H. Supervision in liaison psychiatry. *General Hospital Psychiatry* 2(4):294-299, 1980.

This paper reports special problems and techniques of teaching liaison and consultation psychiatry to psychiatric residents. It has become apparent that traditional methods of resident training are inadequate, and that specialized techniques of supervision are required to help the resident deal with the unique aspects of the liaison and consultation environment.

504. Stevens, J.; Yock, T.; and Perlman, B. Comparing master's clinical training with professional responsibilities in community mental health centers. *Professional Psychology* 10(1):20-27, 1979.

A total of 100 directors from randomly selected, federal funded community mental health centers and 70 coordinators from university-based, master's-level clinical training programs were surveyed by mail to investigate relationships between training and professional responsibilities that master's level clinicians are

expected to meet in community mental health centers (CMHC's). Master's level clinicians were seen as competent professionals having a continuing role in mental health service delivery. Center directors, as compared with training program coordinators, perceived master's-level clinicians to be significantly more competent in the following areas: child individual, child group, and other psychotherapy and counseling; administrative skills; and consultative skills. The importance CMHC directors placed on future acquisition of consultative skills by master's-level clinicians may indicate the need for a shift away from emphasis on research and psychology in many training programs. Implications for training, provision of service, and degree recognition were considered.

505. Strenecky, B.J.; Condon, M.W.; Strenecky, M.K.; and Brown, J.H. Interdisciplinary training of counselor-consultants and reading specialists. *Viewpoints in Teaching and Learning* 54(1):29-34, 1978.

Describes a pilot program for interdisciplinary preservice training. Its main function was to integrate specific dimensions of the educational programs for counselor-consultants and reading specialists. The students involved were enrolled in either counseling or reading education. The program enabled them to communicate with each other, work together on children's problems, learn about each other's role, and become convinced that their relationship was useful. A preservice practicum that would involve other professionals is envisioned.

506. Stum, D.L. DIRECT: A consultation skills training model. *Personnel and Guidance Journal* 60(5):296-302, 1982.

Although counselors and other helping professionals are urged and expected to consult, training models are still needed to promote learning of specific consultation skills. This article presents the directed individual response/educational consulting technique (DIRECT). The model delineates seven steps in the consulting process and further specifies four levels of appropriate consultant "leads" to facilitate the development of each step. The DIRECT model is specifically designed to promote development of interview skills.

507. Swensen, C.H. A symposium on evaluation of training for consultation. *Professional Psychology* 9(2):183-219, 1978.

Papers from a symposium during the annual meeting of the American Psychological Association in Montreal in 1973 describe programs for training students to consult in a variety of settings with a variety of goals.

508. Taylor, C.I.; Shaw, D.L.; Taylor, P.; and Malcolm, R. Psychiatry for medical interns: A teaching model. In: American Psychiatric Association. Continuing Medical Education: Syllabus and Proceedings in Summary Form. Washington, D.C.: the Association, 1978. p. 86.

A summary of a paper read at the 131st Annual Meeting of the American Psychiatric Association, held in Atlanta, May 1978, is presented. A program for teaching consultation/liaison psychiatry principles to nonpsychiatric house staff in a medical university setting is described. Objectives for the program are discussed. The development and content of a comprehensive outcome evaluation are reviewed. The program, its evaluation, and achieved results are described in detail. The program's assets and liabilities, as well as implications for further training and research, are reported. (abs.)

509. Trent, P.J.; Orleans, C.S.; and Houpt, J.L. Models for evaluating teaching in consultation-liaison psychiatry: An overview. *General Hospital Psychiatry* 1(2):104-107, 1979.

Two models for evaluation of teaching in consultation/liaison psychiatry, decision-oriented and conclusion-oriented research, are described. These models, based on previous studies of educational evaluation, are defined in terms of their purpose for liaison psychiatry. To clarify the models' usefulness, the methodological requirements for each model are presented and the unique characteristics of the liaison environment are described in terms of their effect on conclusion-oriented evaluation. (abs.)

510. Weddington, W.W., Jr.; Hine, F.H.; Houpt, J.L.; and Orleans, C.S. Consultation-liaison versus other psychiatry clerkships: A comparison of learning outcomes and student reactions. *American Journal of Psychiatry* 135(12):1509-1512, 1978.

Learning outcomes and student reactions to consultation/ liaison clerkships were compared to those of more traditional psychiatric clerkships. Results indicate equivalent mastery of basic psychiatric knowledge and skills and equally favorable student reactions after psychiatry clerkships for both consultation/liaison and traditional psychiatric clerkships. Further research into the unique contributions of consultation/liaison clerkship training--to knowledge, skills, and attitudes for holistic primary care--is recommended. (abs.)

511. Weinstein, R.S. Teaching community intervention in a clinical program: Reflections in the themes of supervision. *American Journal of Community Psychology* 9(6):681-696, 1981.

Describes the problematic themes that graduate student trainees bring to the supervision of consultation, and explores the influence of the organizational base for teaching on both the structure and the process of the field experience. These thematic struggles, in part generic to the community interventionist role and in part a function of the pattern of institutional arrangements that frame the training experience, are analyzed, and recommendations are made for structural changes that would facilitate training in community intervention.

512. Wellisch, D.K., and Pasnau, R.O. Psychology interns on a consultation-liaison service. *General Hospital Psychiatry* 1(4):287-292, 1979.

A consultation/liaison service training program offered by UCLA for psychology interns is described. Interns serve as general consultants for 6 months in a variety of medical clinics and services, providing direct patient services as well as working with medical staff. Goals, both general and specific, of the program are enumerated. The program is an elective. Each intern is assigned a supervisor with whom weekly meetings are held. An infield faculty member is also available for consultation and backup. Evaluation includes a daily, ongoing assessment by a faculty member, supervisor ratings, presentations on consultation/liaison grand rounds, and a dissertation. The overall objective of the program is to train psychologists to meet the psychological needs of the medically ill.

513. Willoughby, R.H. The pediatric psychologist as polyglot: or, Training students to communicate clearly in a multidisciplinary world. *Journal of Clinical Child Psychology* 7(1):55-57, 1978.

Describes an internship training program within a multidisciplinary inpatient pediatric setting. A major task of the pediatric psychologist's training experience is seen as developing the ability to communicate clearly with members of other professional disciplines. The multidisciplinary treatment team is conceptualized as an interdependent functioning system in which the psychologist plays the essential role of communication specialist. Specific procedures found to be successful in facilitating communications between team members and patients and among team members themselves are discussed from the standpoint of pediatric psychology training.

514. Wise, P.S. A training model in consultation. *Psychology in the Schools* 16(4):515-519, 1979.

A training model in mental health consultation in the schools is described, and the teachability of 11 consultation-related skills was assessed. Thirty-two graduate students served as experimental or control subjects. Experimental subjects participated in a six-session workshop that provided training in the 11 consultation skills. The control group received no such training. A factor analysis of the data yielded two significant factors, verbal consultation and nonverbal consultation. Results of analyses of variance indicate that the experimental group outperformed the control group in verbal consultation on a posttest. (abs.)

515. Wise, T.N., and Brantley, J.T., Jr. A consultation-liaison fellowship in a community hospital. *Psychosomatics* 21(3):205-212, 1980.

The structure and content of a consultation liaison training program based in a community hospital affiliated with a university psychiatric residency are described. The curriculum of the liaison fellowship entails a tripartite experience of direct didactic education, clinical work, and research. Special clinical opportunities for the psychiatric fellow in the psychiatric program include studying compliance problems in patients with chronic illnesses and working with patients who have depressive reactions to severe illness. It is concluded that a community hospital can be a viable site of clinical training for the growing field of consultation/liaison psychiatry.

516. Wolkon, G.H.; Peterson, C.L.; and Gongla, P. University-based continuing education and mental health system change. *American Psychologist* 37(8):966-970, 1982.

Describes how a continuing education program successfully effected a change in the organized mental health services in a large metropolitan area. The principles, goals, and outcomes of a program oriented toward mental health system change and using community organization interventions are reported and discussed. Comparisons are made with traditional individually oriented continuing education programs. Mental health professionals were trained in program consultation to community care facilities serving chronic mental patients, and attempts were made to have such consultations incorporated into the organized service delivery systems. It is concluded that university-based continuing education can be a major stimulus and have a major impact on organized mental health delivery systems.

See also:

26, 64, 67, 75, 78, 79, 103, 110, 144, 157, 168, 191, 219, 235, 238, 263, 267, 270, 325, 368, 406, 413, 426, 435, 586, 587, 607, 646, 654, 655, 663, 664, 666, 680, 703, 712, 719, 735, 739, 753, 759, 760, 763, 774, 786, 792, 795, 806, 837, 846.

Ethical Issues

517. Eichelman, B., and Hartwig, A.C. Ethical and consultation issues in the behavioral sciences and terrorism. *Behavioral Sciences and the Law* 1(2):9-18, 1983.

Examines ethics as a process and as an element of philosophy with a long historical tradition. Elements of the professional ethics of a terrorist or hostage event, issues involved with consulting with an institution, and ethical issues for the clinician personally involved in a hostage event are reviewed. Principles articulated by the American Psychiatric Association's Task Force on the Psychiatric Aspects of Terrorism and its Victims are presented as guidelines for psychiatric intervention in hostage or terrorist situations.

518. Engelhardt, H.T., Jr., and McCullough, L.B. Confidentiality in the consultation-liaison process: Ethical dimensions and conflicts. *Psychiatric Clinics of North America* 2(2):403-413, 1979.

Ethical dimensions and conflicts regarding confidentiality in the consultation/liaison process in psychiatry are reviewed. It is noted that the role of the consultant is complex and marked by essential moral tensions, in that the consultant is the agent of the patient, of the attending physician, of the health care team, of the public health concerns of the State, and of his or her own independent interests. It is suggested that the consultant/liaison psychiatrist make choices in favor of respect for patient autonomy both out of regard for patients and for a practice which supports public liberty.

519. Kimball, C.P. The issue of confidentiality in the consultation-liaison process. *Bibliotheca Psychiatrica* 159:82-89, 1979.

Ethical aspects of the liaison/consultation process are examined. It is noted that during this process, intimate details of a patient's past as well as present life are used to illustrate the patient's present reaction to illness, basic personality, and basis for delusions and hallucinations emerging in altered states of consciousness. Considerations of the issues of informed consent,

confidentiality, and the right to privacy may gravely affect the relationships among patients, students, and institutions in the liaison/consultation process. Suggested ways of coping with these issues are discussed, including the development and use of new languages of liaison work which serve to extrapolate from the specific situation to generalize to a larger population. (abs.)

520. Robitscher, J. Potential abuses in legal psychiatric decisions. What's the trouble with psychiatry? *Legal Aspects of Medical Practice* 6(6):57-58, 1978.

Major legal psychiatric decisions made outside the mainstream of private psychiatric practice are discussed in relation to the ethical responsibilities of the practicing psychiatrist. It is noted that approximately 1 million psychiatric legal consultations occur each year but that, despite their importance, they are accepted uncritically and ignored by practicing psychiatrists. Research promoted by the Law Enforcement Assistance Administration and the National Institute of Mental Health and programs within prison systems to deal with deviant behavior are viewed as presenting critical questions of ethics to the profession of psychiatry. It is concluded that practicing psychiatrists must make a hard appraisal of the direction of psychiatry in the United States.

See also:

65, 99, 127, 308, 350, 354, 436, 816.

Hiring and Using Mental Health Consultants

521. Hampson, R.B.; Tavormina, J.B.; Naiman, R.; and Kriendler, J. A special foster care program: Reimbursement for parents and consultants. *Administration in Mental Health* 6(2):147-153, 1978.

Describes the reimbursement-determination component of a community placement program for retarded children. This population makes special demands on foster parents and requires services of consultants to ensure continued placement success. Reimbursement of selected parents must be high enough to recognize the extra effort they expend and low enough to be acceptable to funding sources. The formula used by the program includes the child's level of functioning, special placement circumstances, parents' need for consultative services, and program costs to arrive at the total placement cost and to allocate money to program, parents, and consultants. The actual fee structure of the program is described, and an example of the use of the formula is given.

522. Ryan, C., and Poling, A. Consultation: Some guidelines to aid consumers. *Mental Retardation Bulletin* 8(1):27-37, 1980.

General guidelines are provided for selecting a consultant specializing in the care of the mentally retarded. A systematic approach to the consultation process is advocated and some of the consumer's responsibilities to himself, the consultant, and the person under consideration are outlined. Emphasis is placed on the importance of having realistic expectations, carefully determining and specifying the range of services desired, hiring a person to provide such services, and fairly and objectively evaluating his or her success in so doing. The legal imperatives of carefully handling contractual matters and protecting constitutional rights also are pointed out. (abs.)

See also:

433, 492, 722, 730.

Planning Mental Health Consultations

523. Castrogiovanni, P.; Brunori, F.; Raggi, F.; Raglianti, P.; and Gianfranchi, C. Epidemiological investigation of preliminary planning for counseling in a general hospital. *Archivio di Psicologia, Neurologia e Psichiatria* 41(1): 79-93, 1980.

Accurate planning of psychosomatic consultation in a general hospital was studied. The following tests were administered to 415 patients in an internal medicine unit: self-evaluation depression scale, the social/environmental questionnaire, and the pre-disease questionnaire. Results of the tests show a high incidence of psychopathological (mostly anxious/depressive) and psychosocial problems. It is concluded that due to these results consultation guidelines can be established. (abs.)

524. Lewis, S. Considerations in setting up psychological consultation to a pediatric hematology-oncology team. *Journal of Clinical Child Psychology* 7(1):21-22, 1978.

The factors to be considered in establishing a psychological consultation relationship with a pediatric hematology/oncology team are discussed. Emphasis is placed on the consultant's knowledge and skill as well as the quality of the consultant-consultee relationship. Appropriate reading material, suggestions for team meetings, and steps for initiating the consultation relationship are detailed. (abs.)

See also:

41, 95, 400, 434, 445, 452, 791.

Entry

525. Kaplan, R.E. Stages in developing a consulting relation: A case study of a long beginning. *Journal of Applied Behavioral Science* 14(1):43-60, 1978.

Stages in the development of a consulting relation are described through a case study of an organization new to organizational development. It is noted that little literature on the achievement of collaboration and openness behavior between consultant and client exists. It is argued that before the desired changes in the organization are possible, a metachange is necessary in the organization's capacity to learn and change and to collaborate with change agents. The formative and normative stages of such change are described. On the basis of the case example and the literature, a formulation of the stages of the metachange is presented, and it is argued that change must occur on two levels--the particular units of the organization and the organizational system as a whole. (abs.)

526. Northman, J.E. Innovative programming in school mental health. Search for methodology. *Child Psychiatry and Human Development* 7(3):186-196, 1977.

Entering a system is often regarded as the most difficult aspect of consultation, especially when entry is initiated by the consultant. Issues involved in seeking entry into a school system are considered from the perspective of a university-based consultant interested in developing, delivering, and evaluating innovative approaches to school mental health problems. Experience with a number of school systems leads to several conclusions about the entry process. Foremost is the existence of a difficult, time-consuming period of negotiations involving various school personnel; because of their varying perspectives and different interests, problems emerge that must be resolved successfully in the course of negotiations if a consultation project is to develop. Often this is not possible, and it is therefore suggested that the consultant seeking a school setting approach several systems concurrently.

527. Sovner, R., and Hurley, A.D. Preparing for a mental health consultation. *Psychiatric Aspects of Mental Retardation Newsletter* 2(10):39-40, 1983.

Outlines the basic types of information a consultant needs to carry out a mental health evaluation: (1) reason for referral,

(2) duration of the problem, (3) presence of precipitants, (4) mental retardation information, (5) psychosocial status, (6) primary contact person, (7) current medical problems, (8) current drug therapy, (9) previous behavioral/psychological problems, and (10) family history of behavior. It is concluded that the success a mental health consultant has in making an appropriate diagnosis and/or recommending treatment depends a great deal on the quality of the information that the consultant receives.

528. Witt, J.C., and Elliott, S.N. Assessment in behavioral consultation: The initial interview. *School Psychology Review* 12(1):42-49, 1983.

Describes the initial phase of behavioral consultation and presents nine objectives to be accomplished during the initial consultative interview: (1) explanation of problem-definition purpose; (2) identification (ID) and selection of target behaviors; (3) ID of problem frequency, duration, and intensity; (4) ID of general conditions under which the problem behavior occurs; (5) ID of desired level of performance; (6) ID of client strengths; (7) ID of behavioral assessment procedures; (8) ID of consultee effectiveness; and (9) summary of interview details. Initial problem ID interview appears to be the most difficult and at the same time the most important aspect of consultation. It is concluded that while research on the efficacy of consultation is still appropriate, research on the individual contributions of the various components of consultation, such as the initial interview, is needed. (abs.)

See also:

207, 267.

Implementation

529. Anders, R.L. Program consultation by a clinical specialist. *Journal of Nursing Administration* 8(11):34-38, 1978.

The use of a nurse clinical specialist as a consultant to a nursing staff is offered as a method of improving total patient care. The author discusses the implementation of program consultation for abortion patients by a psychiatric/mental health nurse clinical specialist.

530. McDermott, J.F., Jr. Mental health training for primary care physicians. *Clinical Psychologist* 32(4):25-29, 1979.

Efforts within organized psychology to develop a highly innovative child psychiatry training program are discussed, focusing on the need for mental health training for primary care physicians. It is

argued that mental health professionals need to reverse the trend toward isolating emotional problems and their treatment and move back into the mainstream of health delivery. Implementation of a program at the University of Hawaii School of Medicine which emphasizes liaison between the departments of Psychiatry and Pediatrics, as well as consultation service for special problems, is described.

See also:

255, 268, 394, 752.

Evaluation

531. Barry, J.R. Evaluating organizational consultation in human service agencies. *Academic Psychology Bulletin* 3(2):203-208, 1981.

Suggests that while the evaluation of organizational consultation is becoming a more public activity, there is still much to be learned in this area. The complexity and uniqueness of most organizational consultation have contributed to the paucity of studies evaluating the processes involved in it. The current status of evaluation research in this area is discussed, and problems are identified.

532. Flaherty, E.W.; Barry, E.; and Swift, M. Use of an unobtrusive measure for the evaluation of interagency coordination. *Evaluation Quarterly* 2(2):261-273, 1978.

Existing records maintained by an early prevention project for children whose mental health was at high risk were used to evaluate the development of interagency coordination in the first 8 months of the project. The records provided information on the extent and form of the interagency contacts, on the staff participating, and on the subjects discussed in the contacts. The process required by use of existing records is described, and the advantages and disadvantages of this method are discussed. A major emphasis in the goals of the legislation for the program was that the recipient "provide consultative and coordinating services with other community agencies serving children in the catchment area." The records were used to assess staff activities toward the development of consultative and coordinating services. (abs.)

533. Hart, S. A questionnaire for the examination of psychiatric liaison-consultation programs. *General Hospital Psychiatry* 1(2):129-133, 1979.

Issues in the evaluation of consultation/liaison psychiatric services are discussed, and a questionnaire for the examination of psychiatric liaison/consultation programs is presented. The questionnaire may be used for a global examination of the working structure of liaison/consultation services. Liaison psychiatrists and personnel from the programs of other institutions are urged to participate in the processes of program evaluation. (abs.)

534. Knoff, H.M. The independent psychodiagnostic clinic: Maintaining accountability through program evaluation. *Psychology in the Schools* 19(3):346-353, 1982.

The pressures of Public Law 94-142 have caused many school systems to contract with independent psychodiagnostic clinics for assessments and educational recommendations. These clinics and the contracting school systems must ensure accountable and efficient service delivery, typically through program evaluation. Clinic evaluation should be discussed during contract negotiations with prospective consultees, be individually tailored to consultees' referral problems, and make efficient use of consultation time. An example program evaluation is presented.

535. Meyers, J.; Pitt, N.W.; Gaughan, E.J.; and Freidman, M.P. A research model for consultation with teachers. *Journal of School Psychology* 16(2):137-145, 1978.

Criticizes past research in consultee-centered consultation because of the inadequate description of techniques and subjective criteria not based on directly observable behavior. A research design based on the use of a small number of subjects is proposed as one way to improve this research. This design is then evaluated in relationship to the internal and external threats to validity discussed by Campbell and Stanley (1963).

536. Mulder, M.; Binkhorst, D.; and Van Oers, T. Systematic appraisal of leadership effectiveness of consultants. *Human Relations* 36(11):1045-1063, 1983.

Leadership theory was used to analyze the behavior of and develop an evaluation system for organizational consultants. Three questionnaires were used: a self-generated list of items contributed by the members of the organization themselves, the Influence Analysis Questionnaire, and an overall evaluation. Panels of colleagues judged 23 junior or senior consultants and collaborators. Results suggest that two leadership patterns

operate in the practice of consultants: a mild, personal, "good chap" leadership; and a tough, more powerful leadership.

537. Popkin, M.K.; Mackenzie, T.B.; and Callies, A.L. Consultation-Liaison Outcome Evaluation System: 1. Consultant-consultee interaction. *Archives of General Psychiatry* 40(2):215-219, 1983.

Describes a system designed to (1) establish a concordance hierarchy clarifying consultees' priorities on seeking psychiatric consultation, (2) provide reference points to guide psychiatric consultants' clinical actions, (3) establish tentative standards with which to evaluate the effectiveness of psychiatric consultation, and (4) signal the need for further outcome studies and the development of data-based consultation practices.

See also:

5, 142, 255, 267, 585, 602, 700, 767, 773.

Consultant-Consultee Relationship

538. Attal, C. The child in the hospital. *Revue de Neuropsychiatrie Infantile et d'Hygiene Mentale* 26(2-3):69-72, 1978.

The cooperation and consultation between pediatricians and psychiatrists in a hospital is described. It is shown that the psychological problems and affective repercussions of childhood organic diseases can be managed in a spirit of harmony between psychiatrists and pediatricians instead of in an atmosphere of mutual exclusion. As a result of experiences in children's hospitals, it is found that a mobile psychiatric unit can render inestimable services to the hospital, the ability of the pediatrician to listen is invaluable, and a dialogue between pediatricians and psychiatrists can lessen the conflict experienced by the hospitalized child. (abs.)

539. Cohen, N.L. Integrating pharmacotherapy with psychotherapy: The consulting relationship. *Bulletin of the Menninger Clinic* 44(3):296-300, 1980.

The role of medication in analytic treatment is discussed. Common acceptance of the fact that genetic factors in manic-depressive illness and schizophrenia result in a deficiency in the development of ego functions allows many analytic practitioners to accept a role for drugs ancillary to psychoanalytic therapy. Low doses of neuroleptic drugs may also serve as part of the "support system" in the analytic treatment of some patients with

borderline personality disorder and in some therapeutic work with psychotic patients. Some guidelines for an optimal consulting relationship between an analytic clinician and a mediating psychiatrist are proposed.

540. Davis, D.S., and Nelson, J.K.N. Referrals to psychiatric liaison nurses: Changes in characteristics over a limited time period. *General Hospital Psychiatry* 2(1):41-45, 1980.

The literature on the consultant-consultee relationship within psychiatric liaison nursing is reviewed. Data on 284 referrals from staff nurses to psychiatric liaison nurses in a teaching hospital were examined to discover whether the nature of the referrals changes with the evolving consultation relationship. Referrals were found to change over time in their specificity, focus, level of sophistication, and kind of psychiatric liaison nurse involvement requested. It is suggested that the evolution of the consultation movement has led to psychiatric nursing consultation's becoming an effective mechanism for improving nursing care in the general hospital. (abs.)

541. Etzion, D. Achieving balance in a consultation setting. *Group and Organization Studies* 4(3):366-376, 1979.

The effect of client perceptions of consultant motivation and behavior on client reactions to consultation was investigated. Eight psychology students formed 40 role-playing dyads. Each dyad played two types of consultation, person oriented and problem oriented. Results suggest that clients demand a certain balance between personal support and understanding on the one hand, and expertise, guidance, and decisiveness on the other. When the situation is loaded with one element, clients' reactions are determined by the presence of the other element. (abs.)

542. Fine, M.J.; Grantham, V.L.; and Wright, J.G. Personal variables that facilitate or impede consultation. *Psychology in the Schools* 16(4):533-539, 1979.

Eleven personal variables of the consultant that are considered to be important to effective consultation in the schools and which enhance a working, collaborative relationship are discussed. Some comments on how personal variables of the consultant can be modified to become more effective are presented. (abs.)

543. Fisher, J.V. What the family physician expects from the psychiatrist. *Psychosomatics* 10(9):523-527, 1978.

How a closer, more productive collaboration between the disciplines of psychiatry and family practice can be approached by addressing the needs and expectations that family practitioners and those engaged in the training of future family physicians have for psychiatry is described. Cooperation can be improved if the psychiatrist is aware of the type and frequency of emotional illness encountered by family practitioners, and the typical therapeutic methods used by them; the feedback from the psychiatrist following consultation and referral is improved; and the psychiatrist assists the family physician in obtaining improved understanding. Training programs and innovative models that facilitate cooperation between the physician and the psychiatrist are described. (abs.)

544. Gustafson, J.P., and Cooper, L. Collaboration in small groups: Theory and technique for the study of small-group processes. *Human Relations* 31(2):155-171, 1978.

Discusses the necessary conditions for group members and their consultants to study group processes together. The authors consider how the collaborative working relationship is achieved in other social fields, in the psychoanalytic therapeutic alliance, in the seminars of Balint (1954) for general practitioners, and in the educational-political work of Freire (1970). They discuss the phenomena of noncollaborative small study groups (Bion 1961) and how these might be understood in depth-psychological and social-political terms: as the consequence of errors of abandonment and intrusion and as continuations of average social oppression. They illustrate both the success and failure of neophyte consultants in securing collaboration in these terms and summarize what they consider to be essential: how consultants pass tests of the meaning and strength of their collaborative intentions.

545. Howells, J. Attitudes of psychiatric residential workers toward supervision by psychiatrists. The rent collector. *Social Work Today* 9(32):18, 1978.

Attitudes toward and expectations of psychiatric consultation and psychiatrists by workers in residential therapeutic settings are discussed, and the role of the psychiatrist in residential therapeutic settings is described. It is noted that the role of the psychiatrist must vary depending upon the nature of the particular residential setting. It is argued that, in a multidisciplinary team, it is essential that communication be free flowing, and that the psychiatrist be in a position to cross the boundaries of a number of professional disciplines to explore the interrelationship which

may affect the client. Far from being the outsider making decisions, it is noted that the psychiatrist can become the catalyst drawing together staff from different disciplines and helping them to see the rehabilitative process within a wider perspective.

546. Hughes, J.N., and Falk, R.S. Resistance, reactance, and consultation. *Journal of School Psychology* 19(2):134-142, 1981.

Reviews techniques for dealing with consultee resistance, and their limitations. The social psychological theory of reactance is offered as a useful concept for considering resistance in consultation. Examples of the application of reactance theory to minimize consultee resistance and to use it for positive change are provided. Variables that predict the likely effectiveness of a reactance utilization intervention are described, and ethical issues involved in the application of reactance techniques are discussed.

547. Martin, R.P. Consultant, consultee, and client explanations of each other's behavior in consultation. *School Psychology Review* 12(1):35-41, 1983.

Examines causal explanations offered by client, consultee, and consultant in a typical unsuccessful consultation within the context of attribution theory and research and attempts to show how biased attributions are often made by consultants as well as by consultees and clients. These biased attributions are discussed in terms of a cognitive-perceptual framework rather than the traditional motivation-based defensiveness framework. It is contended that the defensiveness explanation used by consultants to explain consultation is one example of a class of biased attributions. Implications of this cognitive attribution analysis for consultation practice are presented.

548. Perry, S., and Viederman, M. Adaptation of residents to consultation-liaison psychiatry. II. Working with the nonpsychiatric staff. *General Hospital Psychiatry* 3(2):149-156, 1981.

When working with the staff in a general hospital, psychiatry residents may be overly competitive, solicitous, or detached. These defensive reactions often arise because of the special challenges of performing a consultation, including the skepticism about the value of psychiatry and the demeaning or unrealistic expectations about what the psychiatrist can do. Furthermore, the psychiatry resident feels even more challenged if the attitudes and behavior of the staff must be changed for the patient's benefit. To effect this influence on the staff the psychiatry

resident may need to assume a "liaison stance." This stance involves not only establishing a collegial alliance but also using modified therapeutic maneuvers to alter staff behavior. By applying psychodynamic knowledge to understand and potentially to influence the staff, psychiatry residents, as participant observers, can feel less helpless and frustrated by difficult liaison situations.

549. Piersel, W.C., and Gutkin, T.B. Resistance to school-based consultation: A behavioral analysis of the problem. *Psychology in the Schools* 20(3):311-320, 1983.

When attempting to consult with school personnel, psychologists frequently encounter various forms of resistance. The present authors conceptualize resistance to consultation services within a behavioral/cognitive behavioral framework. Also discussed is how resistance can result from contingencies operating at both the system and the building levels.

550. Rigatelli, M.; Curci, P.; and De Berardinis, M. Some experiences of consultation-liaison psychiatry in a university hospital. *Psychotherapy and Psychosomatics* 33(1-2):1-6, 1980.

The authors present some of their experiences concerning psychiatric consultation in a 1,800-bed university hospital. Particular evidence is given to the development which the physician-psychiatrist relationship has had in the long run.

See also:

131, 137, 180, 208, 210, 276, 318, 341, 342, 345, 379, 424, 434, 524, 608, 645, 701, 720.

Research on Mental Health Consultation

General Research

551. Alpert, J.L.; Ballantyne, D.; and Griffiths, D. Characteristics of consultants and consultees and success in mental health consultation. *Journal of School Psychology* 19(4):312-322, 1981.

Selected attitudinal and value characteristics of high- and low-success mental health consultants were considered. Twelve consultants and 15 consultees completed six measures. Consultants were categorized as high- or low-success consultants based on the coding of consultant's logs. Results indicate high- and low-success consultants did not differ on the selected characteristics. Also,

the results indicate that more successful consultants have consultees who are more authoritarian and dogmatic and are more dissimilar to their consultees in level of dogmatism and reported need for assistance. Future investigations will indicate whether the results can be replicated on a more representative consultee sample. (abs.)

552. Babcock, N.L., and Pryzwansky, W.B. Models of consultation: Preferences of educational professionals at five stages of service. *Journal of School Psychology* 21(4):359-366, 1983.

Thirty-four elementary school principals, 43 special education teachers, and 38 second grade teachers were asked to rate their preference for four models of consultation (collaborative, mental health, medical, and expert) at five stages of the consultation process (goal-setting, problem identification, intervention recommendations, implementation, and followup. No between-group difference in preference was apparent, and the collaborative model received the highest rating. A model by stage interaction was also noted.

553. Bergan, J.R.; Byrnes, I.M.; and Kratochwill, T.R. Effects of behavioral and medical models of consultation on teacher expectancies and instruction of a hypothetical child. *Journal of School Psychology* 17(4):307-316, 1979.

Sixty first and second grade teachers were randomly assigned to one of four conditions representing variations in consultation where they were required to teach a hypothetical child to add. The first condition involved face-to-face behavioral consultation in which the consultant cued a teacher to verbalize antecedent and consequent conditions that might affect learning and prompted the teacher to specify the kinds of capabilities that the child would need to master the academic task targeted for instruction. In the second type of behavioral consultation, face-to-face consultation was augmented by a task analysis report specifying prerequisite skills. The third type, medical model consultation, involved face-to-face consultation focusing on temporally remote environmental circumstances accompanied by a traditional psychological report specifying that the child was of low ability. The control group was asked general questions about the school. Results suggested that behavioral consultation with task analysis was associated with significantly more teaching success than was control in the medical model; and behavioral consultation without task analysis was better than medical model consultation. Implications for psychoeducational assessment are discussed within the context of teacher expectations and instruction. (abs.)

554. Bergan, J.R., and Neumann, A.J. The identification of resources and constraints influencing plan design in consultation. *Journal of School Psychology* 18(4):317-323, 1980.

This study investigated the effects of consultant verbalizations on consultee verbalizations about consultee resources that might be used in plan implementation and constraints that might limit the nature of plans implemented in consultation. Interviews of 50 consultants trained in behavioral consultation and participating in a field experience with public school teachers were analyzed. Plan tactic elicitors verbalized by consultants were shown to have a positive effect on the incidence of resources, as opposed to responses not reflecting resources or constraints. Other types of consultant elicitors all had a negative impact on resource incidence when compared to the incidence of other consultee responses.

555. Billowitz, A., and Friedson, W. Are psychiatric consultants' recommendations followed? *International Journal of Psychiatry in Medicine* 9(2):179-189, 1979.

The extent of adherence to psychiatric consultants' recommendations was examined through a review of 273 patient charts. The recommendations were scored as either actively followed, passively followed, or not followed. The results indicate that what resistances to psychiatric consultation do exist are more often resistance to recommendations to the consultee to actively pursue information for diagnosis and less often to recommendations for specific management and treatment issues. It is concluded that the recommendations more likely to be followed are those easily performed by a consultee and leading to direct, tangible results. (abs.)

556. Bossard, M.D., and Gutkin, T.B. The relationship of consultant skill and school organizational characteristics with teacher use of school based consultation services. *School Psychology Review* 12(1):50-55, 1983.

Ten elementary schools (10 principals, 158 teachers) were each assigned a graduate-student consultant for two half days per week for 14 weeks. During the last week, the consultative skills of each consultant were rated with the Consultant Observational Assessment Form by two "expert" consultants. At the end of the 14th week, teachers and participating consultants assessed the organizational characteristics of each school and each principal's behavior on the Organizational Climate Description Questionnaire and the Leader Behavior Description Questionnaire, respectively. Regression analysis indicated that 70 percent of the variance of

teachers' use of school-based consultation services was accounted for by a linear combination of consultant skill, school organizational climate, and principal leadership behavior. There were significant and robust relationships between teachers' and consultants' ratings of organizational climate, principal initiating structure, and principal consideration.

557. Callies, A.L.; Popkin, M.K.; MacKenzie, T.B.; and Mitchell, J. Consultees' representations of consultants' psychiatric diagnoses. *American Journal of Psychiatry* 137(10):1250-1253, 1980.

In an attempt to characterize consultees' representations of consultants' psychiatric diagnoses, the medical records from 190 psychiatric consultations in a general hospital were reviewed. Using specific outcome criteria, 50 percent of the representations were rated as concordant and 39 percent as nonconcordant. Five variables, including the primary medical diagnosis at discharge and the referring service, were significantly related to concordance. Surprisingly, concordance was independent of the psychiatric diagnosis, indicating that consultees did not respond differentially to varying magnitudes and implications of the different disorders. Results raise the question of possible strategies to improve receptivity to psychiatric diagnoses in the consultation setting. (abs.)

558. Cowen, E.L.; McKim, B.J.; and Weissberg, R.P. Bartenders as informal, interpersonal help-agents. *American Journal of Community Psychology* 9(6):715-729, 1981.

The informal interpersonal help-giving behaviors of 76 bartenders were studied through exploratory interviews. It was found that about 16 percent of the customers raise moderate to serious personal problems. The types of personal problems that came up and bartenders' handling strategies and feeling reactions when such problems were raised were recorded and analyzed. Due in part to the hectic nature of the bar situation, bartenders are less able to engage personal problems in depth than are other informal help-agents, for example, beauticians. They are also less interested in prospective mental health consultation. Thus, although personal problems do come up frequently at the bar, methods for superficial handling and/or referral, rather than in-depth engagement of such problems, seem more consistent with the realities of that work situation. (abs.)

559. Craig, T.J. An epidemiologic study of a psychiatric liaison service. *General Hospital Psychiatry* 4(2):131-137, 1982.

Examination of 308 consultations revealed substantial differences in referral rates related to the demographic, clinical, and programmatic characteristics of patients and services. Across all services studied--medicine, neurology, surgery and obstetrics/gynecology--consultation appeared mainly directed at establishing a specific psychiatric diagnosis and treatment. Markedly different patterns of emotional disturbance were noted across different medical disease categories.

560. Cramer, B.; Feihl, F.; and Palacio-Espasa, F. Juvenile diabetes, a disease difficult to live with and think about: A multifocal psychiatric study of diabetic children. *Psychiatrie de l'Enfant* 22(1):5-66, 1979.

Psychological and psychiatric aspects of juvenile diabetes were studied by three methods: observation of consultations, interviews with parents and children, and psychoanalysis of two juvenile diabetics. The effects of the disease on the patient's mind and mental health, restrictions and treatments required, various forms of positive and pathological adaptation, and the etiology of the disease are discussed. It is concluded that a study of diabetes requires an examination of the psychological aspects of the disease and of the concept of traumatism. A proposal is made to institute supportive psychopedagogy of juvenile diabetes within the framework of medical psychology. Such psychopedagogy would be led by a multidisciplinary team including a psychiatrist. (abs.)

561. D'Alonzo, B.J., and Wiseman, D.E. Actual and desired roles of the high school learning disability resource teacher. *Journal of Learning Disabilities* 11(6):390-397, 1978.

To investigate the role of expectations of the high school learning disability resource teacher, a behavior scale was developed to which incumbents responded according to their actual and desired role performance. Inspection of data from 134 resource teachers indicates that there are few areas of consensus among the respondents. The following aspects of role performance of high school learning disability resource teachers were surveyed: program planning, inservice education, processing referrals, evaluation and student placement, student staffings, student diagnosis, remedial instruction, consulting and resource role, team teaching and counseling, program evaluation, career education and work experience, and parent counseling. It is recommended that further refinement of the behavior scale should be

undertaken to reflect recent changes in state and national legislation. (abs.)

562. Drotar, D. Adaptational problems of children and adolescents with cystic fibrosis. *Journal of Pediatric Psychology* 3(1):45-50, 1978.

Common adaptational disturbance of children and adolescents with cystic fibrosis seen at a major treatment center over a 4-year period are reviewed. Common presenting problems included learning disturbances, problems of behavioral control, somatic symptoms, anxiety, and depression. These disturbances, which often reflected maladaptive family responses to disease-related stresses, posed diagnostic dilemmas and necessitated a range of mental health and consultation services. The implications of these finding for mental health professionals working with chronically ill children and their families are discussed. (abs.)

563. Dyke, C.V.; Rice, D.; Pallett, P.; and Leigh, H. Psychiatric consultation: Compliance and level of satisfaction with recommendations. *Psychotherapy and Psychosomatics* 33:14-24, 1980.

As a measure of the effectiveness of psychiatric consultation, the authors assessed the level of compliance and consultee satisfaction with their recommendations in 55 consecutive cases.

564. Etzion, D. Consultant's involvement and its consequences in consultant-client verbal interaction. *Journal of Counseling Psychology* 27(1):1-8, 1980.

The relation between type of consultant involvement and consultant-client verbal interactions was investigated in an analogue study. A group of 48 undergraduate psychology students formed 24 consultant-client dyads and played in two consultation sessions, each of which portrayed a different type of consultant involvement. Tape recordings of these 48 sessions were rated for ratio of consultant's speech, ratio of mutual verbal interruptions, and ratio of stimulus response congruence. Results show that instructions eliciting the consultant's involvement in the problem as compared with those instructions creating involvement with the client result in a higher level of verbal activity on the part of the consultant, more frequent mutual interruptions, and more response incongruence in the conversation. Individual differences tend to be preserved consistently across the experimental conditions. Results are discussed in relation to other studies employing noncontent measures of verbal behavior in interviews. (abs.)

565. Fava, G.A., and Pavan, L. Consultation psychiatry in an Italian general hospital: A report on 500 referrals. *General Hospital Psychiatry* 2(1):35-40, 1980.

Five hundred consecutive referrals to the psychiatric consultation service at the University of Padua School of Medicine have been reviewed. In 69 percent of cases, concurrent physical and psychiatric disorders were reported. There was a prevalence of females, working class patients, and individuals with limited schooling. Depression was the most common psychiatric disorder in all classes of organic disease and accounted for 37 percent of all psychiatric diagnoses, followed by anxiety neurosis (18.6 percent) and drug dependence (13.8 percent). In 10.8 percent of cases no psychiatric diagnosis was made.

566. Gutkin, T.B. Relative frequency of consultee lack of knowledge, skills, confidence, and objectivity in school settings. *Journal of School Psychology* 19(1):57-61, 1981.

Although Caplan hypothesizes that the majority of consultation cases result from consultee lack of objectivity, there has been no empirical examination of the relative frequency with which consulting school psychologists encounter each type of consultee difficulty. To assess this, in the present study ten school psychology consultants rated the primary consultee problem for each consultation case they had. Contrary to Caplan's assumption, data analyses indicated that significantly more consultation cases resulted from consultee lack of knowledge skills and confidence than from consultee lack of objectivity, which accounted for only 7 percent of the cases. These findings question the practical utility of psychodynamically oriented Caplanian techniques for consulting school psychologists. Because the preponderance of consultation cases develop from consultee lack of knowledge, skills, and confidence, school psychologists would be best advised to focus on the development and utilization of problem solving, behavior analysis, and sophisticated communication skills as their principal consultative strategies. (abs.)

567. Gutkin, T.B. Teacher perceptions of consultation services provided by school psychologists. *Professional Psychology* 11(4):637-642, 1980.

Teacher perceptions of school psychology consultation services were examined. Schools from a wide range of communities were provided with school psychology consultants for a period of 14 weeks. At the end of the time, teacher attitudes concerning the consultation process were assessed. Data analyses reveal that these teachers reacted very positively to the consultation services, placed a high priority on working along with school

psychology consultants, and believed that their professional skills would improve as a function of consultation interactions. None of the results differs between schools as a function of gross demographic characteristics. (abs.)

568. Hales, R.E., and Borus, J.F. Teaching psychosocial issues to medical house staff: A liaison program on an oncology service. *General Hospital Psychiatry* 4(1):1-6, 1982.

In a 1-year controlled study, the authors assessed the impact of an active consultation-liaison teaching program on the attitudes of medical house officers toward psychosocial issues related to the care of oncology patients, consultation/liaison psychiatry, and its importance for them and their patients. Fifty medical interns, residents, and fellows, divided into a test group ($n = 25$) and a control group ($n = 25$), were followed during a 1-year period. A 52-item questionnaire was administered to test group subjects before and after a 1- to 2-month clinical rotation on the hematology/oncology service, and to the control group members at similar intervals. After their experience with consultation/liaison psychiatry, the test group members showed a significant positive change in the importance they placed upon psychiatric consultations, case presentations, and the role of psychiatrists in the development of their attitudes toward the psychological care of cancer patients. The house officers also recorded significant positive changes in their attitudes toward the effectiveness and role of the consultation/liaison service in educating and assisting them in learning more about psychosocial issues. The control group demonstrated no significant change.

569. Hengeveld, M.W., and Rooymans, H.G. The relevance of a staff-oriented approach in consultation psychiatry: A preliminary study. *General Hospital Psychiatry* 5(4):259-264, 1983.

According to the literature, a patient-staff conflict or intra-staff conflict is often the hidden reason for requesting a psychiatric consultation. The present study determined the percentage of consultations in which such "staff problems" play a clinically relevant role. Indications of staff problems were found in one-third of 313 consultations investigated on a consultation/liaison service. These problems occurred significantly more frequently in patients admitted to surgical wards and in patients referred because of psychological disturbances related to their physical disorder, with a "transient situational disturbance" or "no psychiatric disorder." Consultants with relatively less experience diagnosed significantly more staff problems. In about half of the consultations with staff problems, a staff-oriented approach was

applied. Lack of communication with the ward staff in question was the most frequent obstacle to applying such an approach.

570. Heron, T.E., and Catera, R. Teacher consultation: A functional approach. *School Psychology Review* 9(3):283-289, 1980.

Results from seven learning disabled male 6- to 12-year-olds indicate that a competent principal, supervisor, or resource room teacher can increase student productivity and teacher skill in the decision-making process by employing behavioral consultation approaches.

571. Jason, L.A., and Ferone, L. Behavioral versus process consultation interventions in school settings. *American Journal of Community Psychology* 6(6):531-543, 1978.

Teachers experiencing difficulties on the management of disruptive acting-out 1st-grade children were provided with either behavioral or process consultation. The behavioral condition included discussion of behavior modification principles, feedback concerning contingent praise, and individualized behavioral interventions. In contrast, the process condition used clarifying, supportive, and relective responses to help teachers better understand classroom problems and to enhance ability to work with problem children. Results indicated that during consultation and followup, classroom problems were significantly reduced and attention to desirable behaviors significantly increased. While both teachers rated problem children as less disruptive following consultation, classroom observation confirmed this only for the three children in the behavioral classroom. (abs.)

572. Jason, L.A., and Ferone, L. Promoting good mental health from primary to early secondary grades preventive interventions in schools. *Creative Child and Adult Quarterly* 5(1):43-59, 1980.

A 4-year research effort aimed at developing preventive educational interventions for children of inner-city schools is described. The initial thrust was secondary prevention: identifying early childhood disorders and formulating consultation programs to remediate problems. The direction changed over time to a primary preventive orientation in which entire classes or groups of children received experiences to build social, problem-solving, and peer-tutoring skills. Others were involved in programs to prevent onset of smoking or to master critical developmental transitions. The implications of new emphasis on primary prevention are discussed as one step toward promoting good mental health from primary to early secondary grades. (abs.)

573. Keys, C.B., and Kreisman, R.L. Organization development, classroom climate, and grade level. *Group and Organization Studies* 3(2):224-238, 1978.

The effect of school participation in an organization development program on classroom climate and interpersonal behavior was examined. Three experimental schools participated in a 16-month organization development program that included organization training for teams, interschool coordinating council, inservice training, and followup consultation. Three matched control schools did not participate. A classroom climate measure was administered to 593 male students in the 6th, 7th, and 8th grades from the experimental and control schools. To evaluate interpersonal behavior, students participated in experimental games. It is reported that the relationship between participation in an organization development program and positive classroom climate declined as grade level increased. It is concluded that interpersonal behavior and participation in the program were not related. (abs.)

574. Kirschenbaum, D.S.; Devoge, J.B.; Marsh, M.E.; and Steffen, J.J. Multimodal evaluation of therapy versus consultation components in a large inner-city early intervention program. *American Journal of Community Psychology* 8(5):587-601, 1980.

Cincinnati's Social Skills Development Program (SSDP) used a social competence model to direct its interventions for children. Systematic screening identified 15 to 25 percent of the primary grade children who showed behavioral problems and deficits in social skills at seven elementary schools. Multimodal evaluations comparing therapy and consultation interventions included three types of assessments over a 1-year period. Tests of social skills revealed that children who received both therapy and consultation services, compared to those who received only consultation, improved in a basic empathy skill and increased their externality in locus of control. School record data showed that therapy and consultation children improved in grades, but that consultation children improved most. Trained observers also found that therapy children increased cooperative interactions with teachers and maintained appropriate solitary behaviors. These findings support the hypothesis that therapy produces increased benefits for children compared to the less costly consultation intervention. (abs.)

575. Klos, D.M.; Dielman, T.E.; Curtis, G.C.; and Krol, R.A. Validation of a scale for measuring attitudes toward psychiatry in medicine. *International Journal of Psychiatry in Medicine* 11(2):161-172, 1981-1982.

An 80-item scale for measuring attitudes toward psychiatry in medicine was developed and tested. Item selection from the initial 160 items was based on factor analysis and internal consistency of the eight resulting subscales, six subscales exhibiting Cronbach Alpha coefficients ranging from .79 to .95, with two showing coefficients of .57 and .59. The subscales were sensitive to differences in medical specialty, with consultation/liaison psychiatrists exhibiting the most favorable attitudes and highly specialized physicians showing the least. The subscales correlated significantly with subscales of the Zimny Medical Specialties Preference Inventory related to preference for psychosocial and nonspecialized medical activities.

576. Korelitz, A., and Schulder, D. The lawyer-therapist consultation team. *Journal of Marital and Family Therapy* 8(1):113-119, 1982.

Discusses a 6-month pilot study in which joint consultations with a family therapist and a matrimonial attorney were offered to ten couples and one woman contemplating divorce. Sessions were videotaped and concentrated on both emotional and legal issues. A project addendum was done. It is recommended that courses on family dynamics and systems therapy be included in law school curriculums and law courses be included in counseling curriculums.

577. Lewis, M. Child psychiatric consultation in pediatrics. *Pediatrics* 62(3):359-364, 1978.

The results of a 3-month study of the incidence of child psychiatric consultation requests in three different locations (emergency room, primary care center, and pediatric wards) within a pediatric service in a teaching hospital are reported. Of a total of 128 consultation requests, the greatest number (37) occurred in the primary care center, which reflects the increasing number of children receiving pediatric ambulatory care in the hospital, as well as the increasing number of psychological problems diagnosed in this patient population. The second largest number of consultation requests was for suspicion of child abuse. Consultation requests in primary care and in the adolescent and pediatric wards came mostly from pediatricians. Psychiatric diagnoses for children seen in the general pediatric ward included depression, unsocialized aggressive reaction, immaturity, stress reaction, and learning disorder. Future trends and roles for child psychiatry and pediatric collaboration are discussed. (abs.)

578. Lipowski, Z.J., and Wolston, E.J. Liaison psychiatry: Referral patterns and their stability over time. *American Journal of Psychiatry* 138(12):1608-1611, 1981.

The authors analyzed referral patterns for psychiatric consultation from medical and surgical wards on the basis of 2,000 referrals. They found that patients' demographic characteristics were stable over time. The diagnoses of depressive disorders and organic brain syndromes consistently predominated. Other studies have shown similar findings. The authors stress the importance of research on depressive disorders in the physically ill and of teaching the diagnosis of organic brain syndromes. They also underscore the value of the liaison nurse.

579. Loney, J.; Weissenburger, F.E.; Woolson, R.F.; and Lichty, E.C. Comparing psychological and pharmacological treatments for hyperkinetic boys and their classmates. *Journal of Abnormal Child Psychology* 7(2):133-143, 1979.

The short-term effects of methylphenidate and of teacher consultation on the on-task behavior of diagnosed hyperkinetic outpatient boys and selected classmates were compared. Statistically significant treatment effects were found for both drug-treated and behaviorally treated hyperkinetic boys; the extent of these effects did not differ between the two types of treatment. Within the behavioral group, the treatment effect spilled over, so that there was also a significant treatment effect on their average classmates. (abs.)

580. Martin, R.P., and Curtis, M. Effects of age and experience of consultant and consultee on consultation outcome. *American Journal of Community Psychiatry* 8(6):733-736, 1980.

The extent to which the absolute age and experience of the teacher, and the relative age and experience of the psychologist and teacher, affect the outcome of consultations between psychologist and teacher was examined. Data indicate that for each subsample and for the total sample, the teachers in the failure cases were older and more experienced than in the successful cases. Further analysis revealed that for success experience the psychologist and teacher tended to be about the same age; however, for failure experience the teacher tended to be older than the psychologist. For the success experience, the number of years' experience of the psychologist and teacher were very similar; however, for the failure experience the teacher tended to be more experienced than the psychologist. Results strongly

support the opinion that consultation with older, more experienced teachers is more difficult than consultation with younger teachers. Results also demonstrate that psychologists tend to be more successful when consulting with teachers who are closer to their age and experience than with teachers who are older and more experienced.

581. Mayer, G.R.; Butterworth, T.; Komoto, T.; and Benoit, R. The influence of the school principal on the consultant's effectiveness. *Elementary School Guidance and Counseling* 17(4):274-279, 1983.

Principals of nine elementary and junior high schools selected two respected, competent, and motivated teachers to participate in a project assessing the effectiveness of counselors in facilitating teacher behavior change in project teachers. Two other teachers from each school were also selected to permit measurement of the spontaneous generalization of the project or nonproject classrooms. Six advanced graduate students served as counselors at the schools. During the 3-month baseline phase of the project, vandalism cost data were collected. Consultants visited each project classroom on an average of twice a week for five months to collect observational data and assist project teachers in setting up programs designed to eliminate factors involved in student nontask and disruptive behavior and school vandalism. Teams consisting of the principal, the counselor or the psychologist, and the two project teachers were trained during ten 2-hour project workshops. Consultants rated the degree of principal support and cooperativeness, the extent to which project teachers implemented the programs, and the spillover effects. Results indicate that the school with the greatest principal support and cooperation implemented more projects and reduced vandalism costs more than schools with less principal cooperation.

582. MacKenzie, T.B.; Popkin, M.K.; Callies, A.L.; and Kroll, J. Consultation Outcomes. *Archives of General Psychiatry* 40:1211-1214, 1983.

The frequent coexistence of psychiatric and medical illness supports the need for excellent medical care on inpatient psychiatric services. Effective use of consultation is an important element in ensuring this care. In our study of medical/surgical consultation to an inpatient psychiatric service during a 2-year period, outcome variables such as frequency of and concordance with drug and diagnostic action recommendations were determined and compared with similar data for psychiatric consultations to medical/surgical services. Thirty-eight percent of cases received a consultation. Patients seen by a consultant had a longer hospital stay. Twenty-seven and 46 percent of consultations contained

a drug or a diagnostic action recommendation, respectively. The concordance of psychiatric consultees was 79 percent for drugs and 75 percent for diagnostic action recommendations. Comparison with medical/surgical consultations done by psychiatric consultants revealed important differences and similarities. (abs.)

583. Medway, F.J., and Forman, S.G. Psychologists' and teachers' reactions to mental health and behavioral school consultation. *Journal of School Psychology* 18(4):338-348, 1980.

Forty school psychologists and 58 elementary school teachers were shown videotapes of a psychologist consulting with a teacher while using either behavioral or mental health consultation techniques. Problem situations and teacher/consultee verbalizations did not differ across the two sets of videotapes. Afterwards, viewers judged the effectiveness of the consultation and the personal attributes of the consulting parties. In general, teachers preferred behavioral consultation, while psychologists rated the mental health consultation as more effective.

584. Melahn, C.L., and O'Donnell, C.R. Norm-based behavioral consulting. *Behavior Modification* 2(3):309-338, 1978.

Presents a norm-based approach to behavioral consulting. A behavioral code and norms for 32 behaviors were developed for indoor free play situations in Head Start classrooms, with comparisons for age, sex, exceptional status, referral status, and semester reported. Ninety-four female and 92 male children were observed; 29 of these had been referred to a psychological consultant by their teachers as management problems. Thirty-six children were classified as exceptional, because they had special needs of some sort. Results indicate that (1) older children engaged in more cooperative behavior and talking, (2) boys were more active than girls, (3) both exceptional and referred children were involved in more conflicts with their peers and in inappropriate activities, (4) referred children used inarticulate speech more often and received more one-to-one direction from adults, (5) sex and special needs seemed to influence the referral process with the more withdrawn boys and the more active girls being referred, (6) the exceptionals who were involved in less conflict with their peers were more likely to be referred, and (7) inappropriate behaviors declined while cooperative activities increased across semesters. Finally, the use of norms in behavioral consulting is discussed.

585. Nelson, C.M., and Stevens, K.B. An accountable consultation model for mainstreaming behaviorally disordered children. *Behavioral Disorders* 6(2):82-91, 1981.

Describes a consultation model implemented over a 2-year period in a regular elementary school. Data are reported on how consultants spent their time and on the outcomes of consultation for each case served. The model includes procedures for systematizing the consultation process and making it data based and accountable.

586. Orleans, C.S.; Houpt, J.L.; and Trent, P.J. Models for evaluating teaching in consultation-liaison psychiatry: III. Conclusion-oriented research. *General Hospital Psychiatry* 1(4):322-329, 1979.

The purposes and methodological requirements of conclusion-oriented research for evaluating outcomes of consultation/liaison (CL) teaching in psychiatry are reviewed. Requirements for replicating educational methods and outcomes and for demonstrating cause-effect relationships between program inputs and outcomes include careful definition of educational methods, selection of valid and reliable outcome measures, and use of sound experimental designs. Barriers to meeting these criteria in CL settings are identified, and means for overcoming them are suggested. In addition, useful guidelines are provided for the educator wishing to conduct conclusion-oriented CL research into teaching effectiveness. (abs.)

587. Parsons, R., and Meyers, J. The training and analysis of consultation process using transactional analysis. *Psychology in the Schools* 15(4):545-552, 1978.

The possibility of experimentally manipulating the process of consultation was investigated. The process of consultation was conceived in terms of the transactional analysis paradigm. Consultants were trained in transactional analysis and then conducted consultee-centered consultations. The effects of transactional analysis training on adult-adult interactions characterizing consultation sessions, subjective evaluations of the consultants and consultees, and percent of behavioral change toward goal were assessed. Results for two of the four subjects indicate increases in adult-adult interactions, subjective evaluations, and percentage of goal attainment. (abs.)

588. Popkin, M.K.; MacKenzie, T.B.; Hall, R.C.W.; and Callies, A.L. Consultees' concordance with consultants' psychotropic drug recommendations: Related variables. *Archives of General Psychiatry* 37(9):1017-1021, 1980.

To identify variables critical to consultees' concordance with the recommendations of psychiatric consultants for the use of psychotropic medications in a general hospital, the medical records from 394 psychiatric consultations were reviewed. Seven variables were found to be significantly related to concordance. Among these were the patient's history of exposure to psychotropic medications, the presence of multiple recommendations, specification of starting dosage, the category of psychotropic drug recommendation, and the timing of the consultation. The latter two variables emerged as most noteworthy. This work extends the investigation of consultees' responses to consultants' recommendations and anticipates the development of specific consultation strategies derived from quantitative outcome studies. (abs.)

589. Popkin, M.K.; MacKenzie, T.B.; and Callies, A.L. Consultees' concordance with consultants' recommendations for diagnostic action. *Journal of Nervous and Mental Disease* 168(1):9-12, 1980.

Consultees' concordance with psychiatric consultant's recommendations for diagnostic action was studied retrospectively. Of 381 initial consultations reviewed, 110 contained one or more recommendations for diagnostic action. Consultee's responses were rated concordant in only 53 percent of these cases. This disturbing outcome, reflecting broad resistance to consultant's practice of making recommendations for diagnostic action, is attributed to consultee's use of a functional vs. organic dichotomy regarding psychiatric disorder. The functional category is argued to be perceived by consultees as a nonmedical entity. The psychiatrist invoked to deal with this nonmedical entity is seen in other than the medical mode and is inconsistently afforded medical privileges. The work implies how wide the gap to medical credibility may be for psychiatric consultants and the need for new consultation strategies incorporating this cognizance. (abs.)

590. Popkin, M.K.; MacKenzie, T.B.; Hall, R.C.W.; and Garrard, J. Physicians' concordance with consultants' recommendations for psychotropic medication. *Archives of General Psychiatry* 36(4):386-389, 1979.

Physicians' concordance with the recommendations of psychiatric consultants regarding the use of psychotropic medications in a general hospital was retrospectively examined in an outcome study. Using medical records in a series of 200 consecutive

consultations, 68 percent of all psychotropics recommendations were found to result in physician responses rated concordant and 24 percent nonconcordant. Resultant concordance ratings are presented according to category of recommendation--i.e., start, adjust, continue, or discontinue--and drug groupings. Data suggest that drug group is not a critical variable in physician concordance. Responses did differ by category of recommendation.

591. Popkin, M.K.; MacKenzie, T.B.; and Callies, A.L.; and Hall, R.C. Yield of psychiatric consultants' recommendations for diagnostic action. *Archives of General Psychiatry* 39(7):843-845, 1982.

Examined the results of diagnostic measures proposed by psychiatric consultants in a retrospective study of 793 medical records. Of 302 recommendations implemented by consultees, 137 yielded abnormal findings. Abnormalities were widely distributed among laboratory determinations, diagnostic procedures, and psychological tests. Findings demonstrate the merits of the diagnostic recommendations offered by psychiatric consultants and underscore the advantages conferred on patient and consultee by a consultant with a firm base of medical knowledge.

592. Pryzwansky, W.B., and White, G.W. The influence of consultee characteristics on preferences for consultation approaches. *Professional Psychology: Research and Practice* 14(4):457-461, 1983.

Recently, consultee preference for a particular consultation approach has received considerable attention. Studies have usually contrasted two forms of indirect service, with no consideration given to the consultee characteristics as a factor influencing preference. In this investigation, 60 consultees were asked to rate four methods of consultation along with a like-dislike continuum scale. In addition, consultee respondents were analyzed according to the consultees' years of experience and generalized control expectancies. The ratings for consultation process remained constant and suggested a strong choice within this conceptual framework for the collaborative approach. Some issues regarding the role consultee preferences should play within the consultation process are introduced.

593. Ries, R.K.; Bokan, J.A.; Kleinman, A.; and Schuckit, M.A. Psychiatric consultation-liaison service: Patients, requests, and functions. *General Hospital Psychiatry* 2(3): 204-213, 1980.

Demographic factors and psychiatric, medical, and psychosocial problems of illness found in 388 patients on a university-based

consultation/liaison service were evaluated. Results indicate that consulted patients suffer from a wide variety of medical problems, are frequently taking psychoactive medications before the consultation, and experience a spectrum of psychosocial problems in coping with their disease. Primary physicians infrequently provided any psychiatric data or reasons for referral other than for depression. Consultants determined what they felt were the motivating reasons for referral and, besides patient psychopathology, found a significant amount of maladaptive illness behavior and staff-patient conflict. Comparison with other studies supports the high incidence of primary (21 percent) and secondary (18 percent) depression in this population and the active involvement in its treatment by consultation/liaison psychiatrists. Research, training, and clinical issues generated by the findings are discussed. (abs.)

594. Rogers, M.P.; Reich, P.; Kelly, M.J.; and Liang, M.H. Psychiatric consultation among hospitalized arthritis patients. *General Hospital Psychiatry* 2(2):89-94, 1980.

The range of psychiatric disorders among hospitalized arthritis patients and their relationship to characteristics of the patient population such as age, sex, and medical diagnosis were examined with 48 patients. Approximately 2 percent of the patients admitted to the arthritis hospital elicited psychiatric consultation. The distribution of psychiatric diagnoses--depression, personality disorders, drug abuse, psychosis, and conversion reaction--was similar to that encountered in an acute general hospital setting. Neither particular medical illness nor sex account for a disproportionate share of the psychiatric consultations.

595. Rust, J.O., and Thigpen, P.S. Predicting successful parent conferences. *Research Communications in Psychology, Psychiatry and Behavior* 3(2):157-168, 1978.

School psychology interns, parents, teachers, principals, and supervisors were asked to evaluate the effectiveness of 43 parent conferences in an attempt to determine the factors that lead to successful parent conferences. Five school psychology interns filled out special forms measuring predictor and criterion variables of 43 parent conferences; parents and teachers were asked to fill out their respective evaluation forms after the conference. Stepwise regressions and correlational analyses indicate that, in the opinion of the teachers, parents, and interns, the most successful conferences were those where parents were actively involved in decision making. Additionally, teachers related conference success with multiple observations of the child in the classroom. Using parent evaluations as the criteria, conferences were most successful when the parents felt that the surroundings

were comfortable. Finally, correlations show a significant relationship between the interns' reports and the parents' willingness to sign agreement forms for school placement. It is concluded that psychologists need to be trained in the consultation process. (abs.)

596. Sack, W.H., and Blocker, D.L. Who gets referred? Child psychiatric consultation in a pediatric hospital. *International Journal of Psychiatry in Medicine* 9(3-4):329-337, 1978-1979.

The question of who receives a child psychiatry consultation was investigated. The consultation patterns in a pediatric hospital were reviewed over a 5-year period and it was found that the overall consultation rate decreased. However, the referral rate for consultation around diagnostic issues remained relatively constant. This underlines the importance of the child psychiatry consultant as diagnostician. In matching a group of children receiving a psychiatric consultation against a group of children who did not, it was found that the former group's charts contained more psychosocial information. However, it is viewed as doubtful that this played any direct role in the generation of the referral per se. It is emphasized that the pediatric hospital is a medical setting and unless the child's psychosocial problems impinge directly on that system, such problems are likely to remain hidden and beyond the scope of the consultation process. (abs.)

597. Safran, S.P. Resource consultant communication and teacher expectations of behaviorally disordered children. *Behavioral Disorders* 8(1):25-31, 1982.

Identified factors in behavioral disorders resource consultant communication that might influence regular educators' expectations. Sixty-eight middle and elementary school teachers were randomly assigned to one of four experimental conditions involving written information descriptions (positive and negative) and videotaped behavior (withdrawn and acting-out). The main effects for the information condition were minimal, but tended to have paradoxical effects, with positive tending to produce lower expectations for items measuring effects on other students in the regular classroom and effects on the child from regular class placement. Findings suggest that the resource consultant should portray a behaviorally disordered child as a student with specific problems that are within the normal range of behavior.

598. Schwartz, A.J. Factors affecting the usage rate for mental health sections of college and university health services. *Journal of the American College Health Association* 28(3):140-144, 1979.

The history of the Mental Health Annual Program Survey is briefly reviewed, and characteristics of the institutions participating in the survey during the 1975-1976 program year are reported. Usage rate data for the sample and procedures employed in determining the predictors of sample variability in mental health section usage rate are described. Variability in usage rate was regressed against six categories of variables, and when the significant predictors included in these categories were pooled, five variables accounted for 95 percent of usage rate variance. These variables were number of weekly interview hours per 1,000 fulltime students, proportion of fulltime staff, visits per patient, time allocated to consultative services, and availability of off-campus resources. (abs.)

599. Simonds, J.F. Psychiatric consultations for 112 pediatric inpatients. *Southern Medical Journal* 70(8):980-984, 1977.

The investigator, a child psychiatry consultant for a pediatric service, studied 112 consecutive consultations, categorizing the presenting psychiatric problems, mental status, psychiatric diagnoses, final physical diagnosis, and psychiatric recommendations. The 112 patients represented 3.4 percent of all pediatric patients in the same age range admitted to the hospital. Girls comprised 59 percent of the sample studied. The most common presenting problems were unexplained physical symptoms, while the most frequent physical diagnoses were seizure disorder and diabetes. Psychiatric diagnoses were made for 82 percent of the patients seen; the most common diagnosis was "reactive" disorder. Specific recommendations for either inpatient or outpatient psychiatric care were made for 42 patients, of whom 23 were known to have followed through with the recommendations. However, most recommendations involved techniques that could be applied by the primary care physician, e.g., advice to parents, counseling the child, liaison with schools, and direction of hospital staff.

600. Slocum, J.W. Does cognitive style affect diagnosis and intervention strategies of change agents? *Group and Organization Studies* 3(2):199-210, 1978.

One hundred fifty-two change agents—corporate trainers, educators, and consultants--were given a list of 24 diagnostic questions they might ask the client organization, questions related to

the change agents' cognitive styles and the tactics most likely used by the change agents to bring about organizational and/or individual change. Results indicate that agents with different cognitive styles did not use different diagnostic information and change tactics. Findings are compared with previous research findings on change agents' personal styles.

601. Steinberg, H.; Torem, M.; and Saravay, S.M. An analysis of physician resistance to psychiatric consultation. *Archives of General Psychiatry* 37(9):1007-1012, 1980.

Chart rounds were conducted with house and nursing staffs to identify those patients with prominent psychiatric problems relating to hospitalization. It was found that physician resistance to consultation was involved in more than 50 percent of cases not referred, usually because the physicians believed that there was no psychiatric problem or the psychiatry could not help, and less often because the physician thought that the patient might become upset or the patient-doctor relationship would be destroyed. The basis of the physicians' resistance was found unjustified in 26 of 29 patients seen, and 23 of these patients were judged to have been helped by the psychiatrist.

602. Stevens, W.F., and Tornatzky, L.G. The dissemination of evaluation: An experiment. *Evaluation Review* 4(3):339-354, 1980.

The utilization of program evaluation methodology in human service agencies was reviewed from the perspective of organizational contingency theory. Adoption of program evaluation was seen as an innovation which would arouse uncertainty in an organization. An experiment with a sample of 37 drug abuse programs was conducted to test two hypotheses: that group consultations with staff would produce more innovation adoption than private consultations with a program director; and that on-site consultations with face-to-face interactions would produce more innovation adoption than telephone consultations. Results indicate strong support for the first hypothesis but more ambiguous support for the second. The dynamics of these findings are considered. (abs.)

603. Szmuk, M.I.C.; Docherty, E.M.; and Ringness, T.A. Behavioral objectives for psychological consultation in the school as evaluated by teachers and school psychologists. *Psychology in the Schools* 16(1):143-148, 1979.

A set of behavioral objectives was developed for the consultant role of the school psychologist, based on Meyers' consultation model. A Likert-type questionnaire was developed to assess the

degree to which 120 teachers and 83 school psychologists agreed on the desirability and actual accomplishment of these objectives. Both groups perceived a difference between the desired role and the role that school psychologists actually fulfill. There were also significant differences between teachers' and psychologists' ratings of the actual role. Psychologists agreed more with the consultation model. Examination of individual items showed greater acceptance of objectives relating to Meyers' level of indirect service to the child and less acceptance of Meyers' levels of direct service to the school system. (abs.)

604. Tranfield, D.R. The psychodynamics of organization development consultants. *Human Relations* 36(6):509-522, 1983.

Preliminary interviewing of 12 organization development consultants suggested that they tended to have a strongly developed ability to idealize and tended to see themselves as being shy individuals with considerable interpersonal difficulties. Such findings, along with an analysis of organization development values taken from the literature, were interpreted from an object relations viewpoint. From this, a hypothesis regarding the psychodynamics of organization development consultants was developed. Operational measures were devised and data collected using the object relations technique. Some indicative findings are reported from fieldwork, and comparisons are made with clinical groups. The difficulties of interpretation and implications for practice are discussed.

605. Weddige, R.L. Psychiatric consultation on medical-surgical wards. *Hospital and Community Psychiatry* 30(6):377-378, 1979.

A record was kept of psychiatric consultation requests in two private general medical/surgical hospitals over a 4-year period, 1973 to 1977. A total of 350 consecutive consultations were documented. Initial consultation lasted 30 to 90 minutes, and most patients were subsequently seen in two 15- to 30-minute visits. Most fields of practice were represented, with the largest number coming from family practitioners and internists. Reasons for consultation requests included patient unmanageability; suicide gestures/attempts; depression, pain problems; and ill-defined physical symptoms. Primary care physicians appeared proficient in holistic care. Breakdown of diagnoses and management in this group of patients is outlined. The experience in these two hospitals indicates that a one-person psychiatric consultation service is a workable and useful entity.

606. Weddington, W.W., Jr., and Blazer, D. Atypical facial pain and trigeminal neuralgia: A comparison study. *Psychosomatics* 20(5):348-356, 1979.

An evaluation of hospital charts of patients who were examined and treated for trigeminal neuralgia and atypical pain over a 5-year period was conducted. Demographic data, pain history, and psychosocial data were gathered from the charts. Psychologic data were gathered from psychiatric and psychologic consultations, and from psychiatric hospitalizations. Results show significant differences between groups in the usage of psychotropic medications, with atypical facial pain patients being prescribed psychotropic medication more often than those diagnosed as trigeminal neuralgic patients. Sixty-seven percent of atypical facial pain patients have had psychiatric or psychosocial consultations, whereas only 5 percent of trigeminal neuralgic patients list such consultations. Findings suggest that physicians' belief that atypical facial pain is a psychosomatic condition has led to psychiatric and psychologic referrals. (abs.)

607. White, G.W., and Pryzwansky, W.B. Consultation outcome as a result of in-service resource teacher training. *Psychology in the Schools* 19(4):495-502, 1982.

Investigates the effects of learning disabilities teacher training for consultation with classroom teachers. Two types of training were compared: communication skills training and conceptual assumptions training. A control group was also used in the study.

608. Wilcox, M.R. Variables affecting group mental health consultation for teachers. *Professional Psychology* 11(5):728-732, 1980.

The contribution of consultant style and group environment to consultee attitude toward the consultant and group mental health consultation was investigated using 150 student teachers who participated in 10-week educational psychology consultation groups as students. Consultees completed a consultant questionnaire, a group environment scale, and two semantic differentials. Discriminant analysis of process variables that contributed significantly to positive consultee attitudes yielded 11 process variables accounting for 94 percent of the variance. The cluster of items reflecting consultant humanistic orientation explained over 45 percent of the variance in attitude toward the consultant. Five process variables contributed significantly to attitudes toward the consultant, with content emphasis of consultant accounting for 22 percent of the variance. Among group environment variables contributing significantly to consultee

attitudes were structured group order and organization. Implications for school-based group mental health consultation are discussed. (abs.)

609. Wrate, R.M., and Kolvin, I. A child psychiatry consultation service to pediatricians. *Developmental Medicine and Child Neurology* 30(3):347-356, 1978.

A review of referrals to the university department of child psychiatry in Newcastle-upon-Tyne, England, demonstrated active consultation and collaboration between the department and pediatric departments. The presence of some psychological disturbance in those children referred from hospital wards was evident to most pediatricians and constituted the most frequent reason for referral. In the authors' view the greatest value of this research is that it highlights a range of disorders of common concern to pediatricians and children's psychiatrists, using not only the terminology traditional in child psychiatry but also employing a descriptive terminology.

See also:

45, 114, 179, 206, 217, 221, 250, 287, 346, 390, 394, 420, 443, 482, 496, 510, 514, 523, 541, 824.

Program Evaluation

610. Alpert, J.L.; Weiner, L.B.; and Ludwig, L.M. Evaluation of outcome in school consultation. *Journal of School Psychology* 17(4): 333-338, 1979.

To further understanding regarding how content of change, degree of change, and initial level of functioning influence consultants' evaluation of consultation outcome, 14 mental health consultants completed a questionnaire. For each of the 18 pre-post consultation ratings on the questionnaire (2 context x 3 degrees of change x 3 initial levels = 18), consultants rated the success of consultation and the degree to which they would like to have been the consultant. Analysis of variance results for both dependent measures indicate main effects for degree of change and initial level. Neither main effects for content nor interaction effects are indicated. It appears that consultants perceive consultation as more successful with and prefer working with consultees who improve the most and who function at a higher initial level. (abs.)

611. Bergman, A.S., and Fritz, G.K. Psychiatric and social work collaboration in pediatric chronic illness hospital. *Social Work in Health Care* 71(1):45-55, 1981.

Recently pediatric literature has noted that pediatric facilities often function as mental health facilities for their patients. There is little acknowledgment of the role of the pediatric social worker in such care. This paper reviews 1 year of child psychiatry consultations in a pediatric chronic illness hospital, with particular attention paid to quality of social work and pediatric and psychiatric collaboration. In the study year, 72 psychiatric consultations were requested for medical patients, the majority requested by the social worker assigned to the medical service. Organizational and theoretical issues of the psychiatric consultation/liason and social work service are discussed as well as disposition of consultations. From the data presented, close collaboration between pediatricians, social workers, and child psychiatrists can be efficient, effective, and offer a high level of continuity for mental health care of children with chronic illness.

612. Colligan, R.C., and McColgan, E.B. Perception of case conduct as a means of evaluating school psychological services. *Professional Psychology* 11(2):291-297, 1980.

The effectiveness of school psychological services was investigated using a 40-item questionnaire to survey the opinions of all possible recipients of such services in a small rural school system. Questionnaire items were grouped into six broad categories (personal/professional qualities of the consultant, teacher involvement, assessment, written communication, parents, and students). Results are discussed in terms of respondent satisfaction by category. The questionnaire should be useful for stimulating ideas for in-service training, as a reflection of the degree of satisfaction with the consultative services. It is also offered as a means of encouraging others to report their experiences in evaluation of this difficult area. (abs.)

613. Conoley, J.C., and Conoley, C.W. The effects of two conditions of client-centered consultation on student teacher problem descriptions and remedial plans. *Journal of School Psychology* 20(4):323-328, 1982.

Nineteen trained consultants implemented two conditions of client-centered consultation and a control condition with 42 student teacher subjects. The dependent measures were skills in describing classroom problems and generating appropriate remedial plans. Both conditions of consultation were effective in improving problem identification skills. Consultation with observation seemed to be related to a faster improvement than was

consultation with no observation. Skills in developing remedial plans were not affected by treatment. (abs.)

614. Curtis, M.J., and Watson, K.L. Changes in consultee problem clarification skills following consultation. *Journal of School Psychology* 18(3):210-221, 1980.

Differences in problem clarification skills of consultees (classroom teachers) after working with high skilled consultants, low skilled consultants, or after no consultation were assessed. Eight consultants were evaluated and classified as being high skilled or low skilled. Transcriptions of neutral interviews with the 24 teachers concerning child-related problems were evaluated prior to and following the experimental period. Results indicated significantly greater improvement in the skills of teachers assigned to high skilled consultants than for those assigned to low skilled consultants or those receiving no consultative services. (abs.)

615. Fauman, B.J., and Fauman, M.A. Resident performance on a psychiatric emergency service. *Journal of Medical Education* 55(12):1033-1036, 1980.

The effects of a rotation on a general hospital psychiatric emergency service were evaluated in six residents participating in the rotation. Residents each spent 3 months on daytime emergency coverage and 2 years on night and weekend call. Each saw an average of 81 patients during the first year and 37 the second. Review of residents' written emergency department consultations over this time indicated that their ability to communicate information about patients did not change. Management of patients and decision-making did change: although residents gained familiarity with psychiatric medications, they were less likely to prescribe them after training than at the beginning; use of the community mental health center diminished over the 2 years; and use of private or resident-staffed hospital wards dropped even more, with State hospitals becoming a more frequent choice for inpatient treatment. Implications are discussed.

616. Fietel, B.; Hamilton, M.; Schmader, L.; and Shah, B.K. Consultation to line staff and its impact on the care of chronic patients. *The Journal of Nervous and Mental Disease* 170(9):561-564, 1982.

This study, a controlled trial comparing active intervention in the experimental wards with routine nursing care in the control ward, was carried out to determine whether long-term chronic deteriorated patients could be taught skills in activities of daily living by therapy aides to improve their quality of life in the hospital. The

results showed that, even in such a short period as 3 months, active treatment produced results which were statistically significantly better than the controls. It is concluded that mental hygiene therapy aides, given adequate support and encouragement, can make measurable and observable improvements in the behavior of long-term patients. The implications of the results are considered. (abs.)

617. Fergus, E.O. Telephone change agency in the diffusion of a program for the elderly. *Journal of Community Psychology* 7(3):270-277, 1979.

Whether telephone consultation subsequent to a 5-day workshop on a geriatric program, called milieu therapy, affected the degree to which the adoption of the program took place in nursing homes and hospitals was examined. The nursing homes and hospitals were randomly assigned to three conditions; following the workshop, five consultations were conducted, one every 2 weeks. Three months after the last consultation, a followup questionnaire was used to examine the extent of program adoption. Results of the study indicate that telephone consultation did not create more information dissemination. (abs.)

618. Gardner, R.; Hanka, R.; Evison, B.; Mountford, P.M.; O'Brien, V.C.; and Roberts, S.J. Consultation-liaison scheme for self-poisoned patients in a general hospital. *British Medical Journal* 6149:1392-1394, 1978.

In a clinical trial of a consultation/liaison scheme, 276 self-poisoned patients consecutively admitted to a general hospital were randomly allocated to medical teams or to psychiatrists for assessment and treatment decisions. Junior doctors and nurses received training in psychiatric assessment and psychosocial management of the suicidal patient. While awaiting trial outcomes, randomization was continued for 13 months and 729 allocations were made. Physicians requested psychiatric opinions for roughly 20 percent of their patients. In other respects medical teams performed similarly to psychiatrists. Provided that due attention is given to training and to ensuring the availability of psychiatric treatment and social work support following assessment, such a consultation/liaison scheme could be adopted in other hospitals. Not only would such a scheme contribute to general medical training, it could also aid in changing unfavorable staff attitudes toward self-poisoned patients. (abs.)

619. Gavin, J.F., and McPhail, S.M. Intervention and evaluation: A proactive team approach to OD. *Journal of Applied Behavioral Science* 14(2):175-194, 1978.

An intensive organization development (OD) program which was undertaken in a nonacademic service department of a midwestern university, under a contract whereby consultation services were exchanged for research opportunities, is discussed. Interventions included interviews and questionnaires, data feedback, problem-solving meetings, and team building exercises. Changes assessed by questionnaires in a pretest-posttest design over a 1-year interval suggested the following: self-perceptions of legitimate, reward, coercive, expert, and referent power changed significantly, indicating for the most part an increase in employees' sense of power within the system. Role stresses tended to decrease over time, and yet an important index of role strain rose significantly. These data argue for increased awareness of possible job strains induced by OD interventions per se. Organizational climate measures evidence little change despite the extensive intervention work; on the other hand, perceptions of specific factors in the work setting were altered. An implication of these data is that "narrow band" interventions might have more visible effects than those resulting from global change strategies. (abs.)

620. Glaser, E.M., and Baker, T.E. "Methods for Sustaining Innovative Service Programs." Final report, NIMH Grant R12-MH-27566. Unpublished paper, 1979.

Effective innovations in mental health services were examined to determine why some services continue in their original settings in viable and healthy form and sometimes spread to other organizations as well, while others of equal value do not survive much beyond an initially successful period of adoption and operation despite a continuing need for what the innovation provides and despite an apparent lack of a clearly preferable alternative. A set of generalizations postulating conditions that facilitate the sustaining of worthwhile change in mental health organizations was developed. A teachable multicomponent model for organization development type consultation to mental health organizations and related institutions aimed, in part, at helping organizations to achieve the optimal conditions of the tentative theory developed for facilitating change was constructed.

621. Gutkin, T.B.; Singer, J.H.; and Brown, R. Teacher reactions to school-based consultation services: A multivariate analysis. *Journal of School Psychology* 18(2):126-134, 1980.

The impact of consultation services on teachers' preferences for consultation versus referral approaches and upon teachers' perceptions of severity of common acting-out, withdrawal, and academic types of pupil problems were investigated. Subjects were 96 teachers whose public and parochial schools were matched and randomly assigned to treatment and control groups. Following a 14-week period during which advanced school psychology graduate students served as consultants in the treatment schools, the Pupil Problem Behavior Inventory (PPBI) was administered to all teachers. The results of a repeated measures multivariate analysis of variance indicated that the teachers in the treatment group rated the acting-out and the academic problems on the PPBI as significantly less severe than did the teachers in the control group. The teachers in both the treatment and control groups indicated a significant preference for consultation rather than referral services for all types of pupil problems presented in the PPBI. There was a moderate positive correlation between perceived problem severity and teacher preference for referral rather than consultation services. The study's results are interpreted as supportive of the consultation model. (abs.)

622. Henker, F.O. III. Enhancing the value of psychiatric consultation. *Psychosomatics* 19(7):394-396, 1978.

The evaluation of a psychiatric consultation service at the University of Arkansas Medical Center is reported along with the changes made as a result of the study and the effect of those changes. Shortcomings were found in the amount of experience of those who performed the consultations, in the timing of the consultations (not prompt enough), and in the tone, legibility, and organization of the reports provided by the consultants, as well as in followup of patients. Steps to resolve these problems have resulted in increased use of the consultation service and an improvement in the quality of psychiatric referrals. (abs.)

623. Knoff, H.M. Evaluating consultation service delivery at an independent psychodiagnostic clinic. *Professional Psychology* 13(5):699-705, 1982.

The independent psychodiagnostic clinic continues to be an important consultation resource for school districts and parents with educationally confusing children. The Psychoeducational Teaching Laboratory at Syracuse University utilizes a multidimensional consultation process to address the needs of all three

parties. The present study evaluated this process through the parent and the school consultees ($n = 33$). Adaptations to the process are recommended, and implications for other independent clinics are discussed.

624. Koran, L.M.; Moos, R.H.; Moos, B.; and Zasslow, M. Changing hospital work environments: An example of a burn unit. *General Hospital Psychiatry* 5(1):7-13, 1983.

A liaison psychiatrist invited to help a burn unit staff explore problems affecting morale and patient care employed a four-step procedure that involved (1) assessing the work environment systematically, (2) giving the staff feedback from this assessment, (3) helping the staff plan and institute changes, and (4) reassessing. The staff completed the Work Environment Scale (WES), a 90-item true-false questionnaire that measures ten dimensions of the actual and preferred work environment. At the second of 12 biweekly meetings, the psychiatrist presented the unit's WES profile and began helping the staff explore and resolve problems. Reassessment 6 months later revealed significant changes on several pertinent WES scales and reduced discrepancies between actual and preferred work environments on nine of the ten scales. Findings indicate that systematic assessment and feedback procedures may help liaison programs improve the quality of hospital work environments and thereby enhance staff performance and morale.

625. Kramer, B.A.; Spikes, J.; and Strain, JJ. The effects of a psychiatric liaison program on the utilization of psychiatric consultations: An evaluation by chart audit. *General Hospital Psychiatry* 1(2):122-128, 1979.

The effects of a psychiatric liaison program were studied by a chart audit examination of psychiatric consultations on a medical service. A comparison of the full liaison ward with the other wards revealed significant differences in the use of emergency consultation and psychiatric followup treatment. Results indicate improved psychologic management of medical patients on wards with intense liaison involvement but no measurable change in attitude toward the psychiatrist. Evaluation methodology and implications are discussed. (abs.)

626. Leyser, Y. The effectiveness of an inservice training program in role playing on elementary classroom teachers. *Group Psychotherapy, Psychodrama and Sociometry* 33:100-111, 1979.

Whether an inservice training program in role playing which includes a workshop and weekly consultation periods in an effective

training model for helping teachers gain a better knowledge and understanding of the role-playing technique and for promoting a more skillful use of role playing in the classroom was investigated. The project was conducted in grades 3 through 5 in 65 classrooms in two school districts; half of the classrooms were randomly assigned to the experimental condition and half to the control condition. All experimental teachers were then involved in a role-playing training program which included a workshop and consultation services. Results show that the program was useful in building the necessary knowledge, understanding, and skills needed for directing role-playing sessions in the classroom. It is suggested that similar programs be offered to teachers in several workshops during the year, and also in colleges training teachers.

627. Lipshitz, R., and Sherwood, J.J. The effectiveness of third-party process consultation as a function of the consultant's prestige and style of intervention. *The Journal of Applied Behavioral Science* 14(4):493-509, 1978.

The present study examines the effects of process consultation on group performance and group cohesiveness. Two factors were studied: (a) the consultant's prestige (high vs. low), and (b) the style of intervention (instrumental process analysis vs. interpersonal process analysis). The results of the study are summarized as follows:

1. Task groups using process analysis, with or without a consultant, improved more in their work processes and cohesiveness than task groups which did not use process analysis.
2. Groups which were facilitated by a third party were not significantly different from groups which performed process analysis on their own.
3. There were no differences due to the prestige of the consultant.
4. Instrumental process analysis was followed by greater improvements in work process and performance than was interpersonal process analysis. There were no differences in cohesiveness as a consequence of the two styles of intervention.
5. The interaction between prestige and styles of intervention did not follow any consistent pattern.

The results of this study are consistent with a "specificity proposition" stating that an intervention is more likely to succeed in

those areas on which it is focused. Implications of this proposition for organization development are discussed in some detail. (abs.)

628. Miller, M.R. Rape consultation and education (unpublished paper). Final report, NIMH Grant 30R18-MH-29003, 1978.

The rape consultation and education process in a rural Arizona poverty catchment area was analyzed, and data regarding the nature and extent of rape in the catchment area were gathered. Detailed discussions are given on consultation and education programs in rural areas, the role of the rape research coordinator, sexual assaults in a rural poverty catchment area, victim characteristics, and assailant characteristics. There is a high incidence of child sexual assault and of incest. Rape in rural areas tends to be intraracial with the highest percentage of both victims and assailants tending to be Anglo-American. Rural rapes are physically violent events, but there appears to be no correlation between violence and group rapes. There is a high incidence of group rapes with an average of 1.42 assailants per assault. There is a high correlation between the use of alcohol and/or drugs in the sample. Victims in rural areas are mostly likely to first seek assistance from either law enforcement agencies or their family and/or friends. The highest risk place in a rural area is in a residence, and a higher percentage of rural rape victims than urban victims know their assailants.

629. Muro, J.J.; Kameen, M.C.; and Brown, J.A. Research and innovation in elementary school guidance and counseling. *Elementary School Guidance and Counseling* 12(4):280-283, 1978.

The efficacy of a specific teacher group consultation approach and its potential impact on teachers and children was studied. Study areas were the impact of videotape teacher group consultations on teacher affective behavior, specifically esprit and intimacy; the impact of a program of guidance services on pupil affective behavior, specifically self-perceptions and peer acceptance; and the relationship between teacher affective behavior changes and pupil affective behavior changes in the presence of these opportunities. The study was conducted in a predominantly white rural elementary school consisting of 714 pupils in grades K-7. There were 22 teachers with 1 to 32 years of teaching experience. The Mac-B Personal Competence Inventory, consisting of self-perceptions and peer acceptance indexes, was administered to the pupils in grades 3-7 at the onset and conclusion of the program to measure the impact of the program on the pupil affective behavior. The impact of teachers

was measured by the Organizational Climate Description Questionnaire subtests on esprit and intimacy. No statistically significant changes in esprit or intimacy for teachers resulted from the videotape group consultations, but individual teachers did change in a positive direction. Pupils made significant gains in both self-perceptions and peer acceptance.

630. Nagle, R.J., and Gresham, F.M. A modeling-based approach to teacher consultation: A case study. *Psychology in the Schools* 16(4):527-532, 1979.

Modeling and modeling with information feedback were employed as consultation strategies to change teacher behavior toward seven trainable mentally retarded children in a self-contained public school classroom. Dependent measures were the length of teacher commands (number of words) and student compliance rate as a function of commands. The results show that modeling alone dramatically reduced the number of words in teacher commands, which had a concomitant effect of increasing compliance rate of the children. Modeling with information feedback had little effect upon command length or compliance rate. Implications for training special service personnel are discussed. (abs.)

631. Neill, J.R. Consultation evaluation: I. Psychotropic drug recommendations. *General Hospital Psychiatry* 1(1):62-65, 1979.

A followup chart review was undertaken of 100 consecutive patients seen in psychiatric consultation for whom psychotropic medication was recommended. Significant differences in implementation by class of drugs--neuroleptics, tricyclics, benzodiazepines--were found. Most often no discernible reason for consultee disagreement could be found or inferred. The importance of such followup studies for consultation work is emphasized. (abs.)

632. Popkin, M.K.; MacKenzie, T.B.; Callies, A.L.; and Cohn, J.N. An interdisciplinary comparison of consultation outcomes: Psychiatry vs. cardiology. *Archives of General Psychiatry* 38(7): 821-825, 1981.

Responses to cardiologists' and psychiatrists' recommendations for drugs and diagnostic actions were compared in a retrospective study of 788 consultations. Variables significantly related to outcomes achieved by cardiologists and

psychiatrists were identified; similarities among these variables were evident only for the drug recommendations. Cardiologists' recommendations achieved a higher rate of concordance than psychiatrists' for both drugs and diagnostic actions. For drug recommendations, the interservice discrepancy in concordance was directly related to differences in timing of the consultations and incidence of recommendations to start a drug. For diagnostic recommendations, however, the difference was directly related to the consultants' service. The following factors may explain the less favorable outcome for psychiatrists' diagnostic recommendations: the reasons for seeking psychiatric consultation, the consultees' expectations and the skill of the psychiatrists in offering these recommendations.

633. Rosenstock, H.A., and Vincent, K.R. Parental involvement as a requisite for successful adolescent therapy. *Journal of Clinical Psychiatry* 40(3):132-134, 1979.

The effect of parental involvement in the treatment programs of 66 consecutive adolescent psychiatric patients was investigated. Adolescents whose parents participated regularly in a parents' group or in individual parental consultation and therapy achieved a 64 percent success rate, using narrow success criteria. For those adolescents whose parents were not involved in the treatment process, the failure rate was virtually 100 percent. There was no significant difference in treatment outcome between parents seen individually and those seen in groups. However, a parents' group is recommended where feasible in lieu of individual parent consultation alone for reasons of catharsis, universality, mutual support, and collective experience. (abs.)

634. Safran, S.P., and Barcikowski, R.S. LD consultant information in mainstreaming: Help or hindrance? *Learning Disability Quarterly* 7(1):102-107, 1984.

Assessed was the impact of information commonly disseminated by consultants on teacher expectations for mainstreamed learning-disabled (LD) students. After receiving varying combinations of positive and negative communications in the areas of reading achievement, classroom behavior, and learning style, 129 regular education teachers completed the Regular Educator Expectancy Scale-Revised--an instrument developed to measure four areas of mainstreaming (instruction, effects on others, effects on the child, and behavior management strategies).

Results indicate that teachers were differentially influenced by consultant information, expectations were differentially affected by the type of information, and support in a specific area could enhance positive expectations in related areas.

635. Sasser, M., and Kinzie, J.D. Evaluation of medical-psychiatric consultation. *International Journal of Psychiatry in Medicine* 9(2):123-134, 1979.

The effectiveness of hospital psychiatric consultation was examined using four approaches: a survey of actual consultation use, a house staff attitudinal survey, a patient chart review, and a patient questionnaire. The findings of the project include (1) psychiatric consultation is underutilized and a large number of house staff find it not useful, (2) psychiatric and nonpsychiatric house staff view the functions of consultations in markedly different ways, (3) a high percentage of written consultation reports are too vague to determine if the needs of the referring physician were met, and (4) patients usually respond positively to psychiatric consultation. It is concluded that the mediation and educational functions of psychiatric consultations are not highly valued by physicians. (abs.)

636. Sbordone, R.J., and Sterman, L.T. The psychologist as a consultant in a nursing home: Effect on staff morale and turnover. *Professional Psychology: Research and Practice* 14(2):240-250, 1983.

Many elderly patients have been transferred from long-term psychiatric hospitals to nursing homes, where knowledge of psychological aspects of patient care is generally poor and where emotional and behavioral disorders are poorly tolerated by staff. One solution to this problem is for psychologists to provide in-service training in the psychological aspects of patient care to nursing-home staff, but this approach ignores such problems as poor staff morale and high staff turnover. A 188-bed skilled nursing home was selected for a 12-week consultation program based on a mental health and organizational development approach. Turnover rates fell from 73.4 percent during the quarter prior to consultation to 27.8 percent during the period of consultation, and averaged 33.6 percent for the next three quarters. Staff morale also improved. Results indicate that before training nursing-home staff in the psychological aspects of geriatric care, problems such as high staff turnover and poor morale should be resolved.

637. Search Institute. Effecting utilization: Experimental use of consultants, phase I report. Minneapolis: Search Institute 1978.

Activities of the first phase of a 3-year project designed to determine the degree to which consultation increases the likelihood of local youth-serving groups' adopting an innovative program of demonstrated worth are discussed. Phase one activities included (1) the involvement of representatives of the youth-serving agencies; (2) development of a survey instrument to assess reactions to change as expressed by individuals in local youth-serving organizations; (3) administration of the survey to a national random sample of local units from each of the five participating national organizations; (4) analysis of the national survey data; (5) development of a profile format and interpretive material to report the survey results; (6) completion of the research design, instruments, and methods of procedure for the second phase of the experiment; and (7) the enlistment of regional samples of local units in the upper Midwest from each of the five youth-serving agencies. The primary goal of the second phase of the field experiment is to determine the impact of consultation approaches based on specific survey information versus the impact of consultation approaches not based on survey information. Phase three is devoted to dissemination activities.

638. Torem, M.; Saravay, S.M.; and Steinberg, H. Psychiatric liaison: Benefits of an 'active' approach. *Psychosomatics* 20(9):598-611, 1979.

The ordinary reactive approach to psychiatric liaison was compared with a more active approach by psychiatrists on two hospital medical units. In the reactive approach, the psychiatrist resident met regularly with the nursing staff to assist with specific patient problems. In the active approach the psychiatrist resident made rounds with the nursing staff and reviewed all patient records. The results indicate that the active approach not only increased the rate of referrals from 2 to 20 percent, but also uncovered a unique group of patients in whom 90 percent of their psychiatric problems bore a close relationship to their current physical illness and hospital treatment. The implications of this finding in designing new liaison consultation services are discussed.

639. Tyler, V.O. Aggressive consultation in the schools with mini-consultants, college credits--and a show of power. *Psychology in the Schools* 18(3):341-348, 1981.

Undergraduate education students were placed in elementary classrooms every morning for 1 year to conduct behavioral projects. These "innocent change agents" stimulated teachers to ponder their teaching by explaining goals and procedures and collecting data. Graduate students in school psychology served as "mini-consultants." The teachers were enrolled in a course for college credits and salary increments and assigned behavioral projects in their classrooms. The 13 teachers who completed the project successfully changed behaviors in 60 to 70 attempts.

640. Van Dyke, C.; Rice, D.; Pallett, P.; and Leigh, H. Psychiatric consultation: Compliance and level of satisfaction with recommendations. *Psychotherapy and Psychosomatics* 33(1-2):14-24, 1980.

Level of compliance and consultee satisfaction with recommendations were assessed in 55 consecutive cases to measure the effectiveness of psychiatric consultation. Overall compliance with the consultants' recommendations was 90 percent and did not vary significantly for the different types of recommendations. The medical staff felt that 60 to 70 percent of the recommendations had a positive effect on patient care and that only 1 to 2 percent had a negative effect. It is concluded that these favorable results have implications both for the care of patients and the training of psychiatric residents. (abs.)

641. Waring, E.M.; Weisz, G.; Heilbrunn, D.; Lefcoe, D.; and Green, R.N. A pilot evaluation of liaison psychiatry in a diabetic outpatient clinic. *Psychiatric Journal of the University of Ottawa* 5(1):53-57, 1980.

A psychiatric liaison service to an adult, outpatient diabetes clinic was evaluated in comparison to a traditional consultation service. Consumer satisfaction and clinical outcome, both psychological and physical, were compared between diabetes mellitus patients with and without psychiatric illness and also between patients treated by the liaison service and a control group. Diabetes patients with psychiatric illness had significantly more medical complications and perceived their illness as more disabling. The psychiatric group also had significant worsening of symptoms during the liaison study and more frequent problems of

diabetic control. Despite full-time clinical attendance, the liaison service recognized only 25 percent of psychiatric cases in a study sample identified by psychiatric epidemiological screening. No difference was demonstrated in outcome between patients seen by the liaison service and those seen by a control group. Psychiatric patients were less satisfied with the care they received. These findings are discussed in the context of future research in the treatment of psychosomatic illness, and an alternative model of liaison psychiatry emphasizing epidemiological models is suggested. (abs.)

642. Wenger, R.D. Teacher response to collaborative consultation. *Psychology in the Schools* 16(1):127-131, 1979.

Teacher responses to a consultant's efforts to foster either a collaborative or an expert consultation relationship were investigated. Eight teachers were exposed to a collaborative approach and seven to an expert approach. Teacher satisfaction with the consultation and extent of their implementation of the recommendations were the dependent variables. Teachers exposed to the collaborative approach were significantly more satisfied. There was no significant difference in extent of recommendation implementation in the two groups, but a consultant approach-teacher experience interaction is suggested. The generalizability of these results and recommendations for design modification for further research are discussed. (abs.)

643. West, J.; Sonstegard, M.; and Hagerman, H. A study of counseling and consulting in Appalachia. *Elementary School Guidance and Counseling* 15(1):5-13, 1980.

The effects of a pupil counseling and consultation program were explored in an elementary school serving a rural, economically deprived population. Services included seminars for teachers to facilitate understanding and management of children's disruptive and problem behaviors, individual and group counseling of teacher and self-referred pupils, tutoring, and implementation of classroom self-understanding exercises. Results indicate that children involved in counseling showed improved classroom behavior and expressed increased self-understanding and personal responsibility; pupils receiving parent aid tutoring improved their reading scores; pupils receiving peer mathematics tutoring showed computational skills; and disciplinary referrals showed a significant decrease in disruptive

behavior incidents compared to referral rates for the previous school year. The self-understanding exercises failed to significantly influence pupil locus of control. While the teachers' groups were not formally evaluated, case materials demonstrated their positive effects.

644. Wiesenfeld, A.R., and Weis, H.M. Hairdressers and helping: Influencing the behavior of informal caregivers. *Professional Psychology* 10(6):786-792, 1979.

In an evaluation of program effects on behavior of informal caregivers, six hairdressers who had participated in a 10-week group mental health consultation and training program were compared with seven control hairdressers on pretest and posttest responses of the Wiesenfeld-Weis Helper Response Inventory. Although on pretest both groups heavily used advice giving and presenting alternatives, only program participants showed an increase in the reflection of feelings response strategy posttest. The consultation program goals included maximization of helping effectiveness through modeling and education about referrals within the local mental health network. It is suggested that training in interpersonal help giving be offered to other groups of informal caregivers. (abs.)

See also:

29, 84, 162, 339, 471, 508, 531.

Surveys

645. Alpert, J.L.; Ludwig, L.M.; and Weiner, L. Selection of consultees in school mental health consultation. *Journal of School Psychology* 17(1):59-66, 1979.

To better understand the selection of teacher consultees, 15 mental health consultants were administered questionnaires. Consultants ranked teachers in their school consultation placements on ability to meet academic and socioemotional needs of children, receptivity to change, and likeability. Next, after indicating which teachers they would most and least like to work with, consultants rated the teachers on nine five-point rating scales. In general, results indicated that most preferred consultees, in comparison to least preferred consultees, were perceived as less needy around issues concerning children and lessons, more responsive to consultation, and more likeable. It appears

that teachers most in need of consultation are not selected for consultation. (abs.)

646. Brook, P. The choice of career of consultant psychiatrists. *British Journal of Psychiatry* 138:326-328, 1981.

All consultants in general psychiatry appointed in Britain between October 1975 and September 1978 were sent a questionnaire asking about their training and adequacy of experience before making a final decision. Over 25 percent of the 162 respondents were women, of whom a third had trained part-time. Family circumstances and availability of part-time posts were important determinants of career choice.

647. Bruhn, J.G.; Scurry, M.T.; and Bunce, H. III. The care of dying patients: Survey of housestaff attitudes and experiences. *Archives of the Foundation of Thanatology* 7(4):97-109, 1979.

The attitudes of hospital housestaff toward dying patients and their medical care were investigated. Responses were received from 136 housestaff members to a questionnaire mainly consisting of 19 attitude statements expressing feelings and reactions toward death and toward dying patients. Few statistically significant relationships were found between sex, level of postgraduate training, and medical specialty and the 19 attitude statements; housestaff attitudes appeared to be quite homogeneous. Most housestaff agreed that they felt uncomfortable with dying patients; and 62 percent said that they had a need for information, consultation, or discussion regarding death and dying. The results are compared to those of other similar studies.

648. Haemmerlie, F.M.; Hughes, C.W.; and Preskorn, S.H. Psychology interns' view of the psychiatric consult. *Journal of Psychiatric Treatment and Evaluation* 5(2-3):277-280, 1983.

Investigated aspects of psychiatric consultation that clinical psychology interns consider important and whether philosophical orientation of training program influences the value these interns place on its various facets. Some 148 clinical psychology interns working in medical settings in 1979 were asked to complete a questionnaire on which they rated various aspects of a routine psychiatric consult and to indicate the orientation of their internship training program.

The majority indicated their program's therapeutic orientation to be either psychodynamic or behavioral. They valued the recommendations about psychiatric medications the most and deemphasized those services either that they typically provided themselves and/or which they may not have realized that the psychiatric consultant can address. In general, training program model did not affect how clinical psychology interns viewed the psychiatric consultant.

649. Karasu, T.B. Utilization of a psychiatric consultation service. *Psychosomatics* 19(8):467-473, 1978.

A survey of how frequently physicians on various services requested consultations was made to clarify the role of the psychiatrist as a consultant in a general hospital. The problems leading to the consultation requests and which psychiatric services the requesting physicians considered most valuable were also surveyed. Results show wide variations between and within the medical services, pointing to the need for the psychiatric consultant to be trained in a multiplicity of consulting roles. (abs.)

650. Koran, L.M.; Van Natta, J.; Stephens, J.B.; and Pascualy, R. Patients' reactions to psychiatric consultation. *Journal of the American Medical Association* 241(15):1603-1605, 1979.

Patients' reactions to a request for psychiatric consultation were examined by interviewing 60 patients 24 hours after the consultation. Nearly two-thirds of these patients believed that the consultation was beneficial. Patients with long-term illnesses more often had positive attitudes than patients with short-term illnesses. Patients who were initially hostile or ambivalent usually had positive attitudes 24 hours later. Substance abusers and patients who denied clearly recognizable psychiatric disorders often did not value the consultation. It is suggested that the positive attitudes of patients in the study were attributable to the referring physicians' preparing them for psychiatric consultation. (abs.)

651. Lacayo, N.; Sherwood, G.; and Morris, J. Daily activities of school psychologists: A national survey. *Psychology in the Schools* 18(2):184-190, 1981.

A national survey of 335 school psychologists (aged under 65 years), asking them to record their activities on a specific school day, showed that assessment activities comprised

nearly 40 percent of the work time and consultative activities another one-third of the day. Data were collected on a number of other work activities, as well as characteristics of the respondents (e.g., languages spoken, characteristics of district served).

652. Martin, R.P., and Curtis, M. Consultants' perceptions of causality for success and failure of consultation. *Professional Psychology* 12(6):670-676, 1981.

Investigated the causal attribution made by consultants with regard to successful and unsuccessful consultation experiences. One hundred sixty-four school psychologists (mean age 32.1 years) were asked to consider their consultation experiences with teachers, select the most and least successful cases they could remember, and then state why they felt each case succeeded or failed. Consultants attributed both success and failure experiences more to characteristics of the consultee than to any other cause, with consultee characteristics considered a greater contributing factor to the failure than to the success experiences.

653. Martin, R., and Meyers, J. School psychologists and the practice of consultation. *Psychology in the Schools* 17(4):478-484, 1980.

A survey of 122 school psychologists determined that consultation is one of their major professional functions and that they feel that other school personnel want them to spend even more of their professional time consulting. Client-centered consultation was the dominant variety practiced by the subjects, who tended to conceptualize their consultation efforts in a humanistic (Rogerian) or behavioristic framework. Age and salary were factors in the amount and type of consultation done. However, most subjects had little formal training in consultation.

654. Meyers, J.; Wurtz, R.; and Flanagan, D. A national survey investigating consultation training occurring in school psychology programs. *Psychology in the School* 18(3):297-302, 1981.

Survey data obtained from 121 school psychology training programs regarding their approaches to consultation training indicate that 40 percent offered at least one course devoted solely to consultation, while 60 percent did not offer such a course; more of the doctoral programs responding offered consultation training than did nondoctoral programs; and

practicum experience was considered an important aspect of consultation training. It is concluded that a greater emphasis on consultation training may help to promote implementation of this role.

655. Miles, J.H., and Hummel, D.L. Consultant training in counselor education programs. *Counselor Education and Supervision* 19(1):49-53, 1979.

A study to ascertain the emphasis in counselor education programs given to consultation in the preparation of counselors is reported. Thirty-one percent of the existing counselor training programs were surveyed. Findings indicate that 44 percent of the programs offered formal courses in consultation; the counselor as consultant was ranked second only to counseling as a major counselor role. Consultant training was reported as mainly focusing on work with individual consultees and small groups. It is recommended that more attention be given to preparation of counselors for the role of consultation. (abs.)

656. Ochitill, H.N. Psychiatric consultation: A survey and review of utilization. *Comprehensive Psychiatry* 24(3):236-243, 1983.

Approximately 51 25- to 39-year-old junior and attending staff physicians from the medical and surgical departments of a university-affiliated general hospital were surveyed regarding estimates of present use and future need for a psychiatric consultation service (PCS), specific acceptability of various facets of PCS, a profile of indications for a PCS request, and who institutes PCS requests. Findings suggest guidelines for increased PCS activities in the departments of surgery and medicine.

657. Preskorn, S.H.; Schreiber, M.; and Hughes, C.W. Attitudes toward psychiatric consultation: Effect of training. *Journal of Psychiatric Treatment and Evaluation* 4(3):313-316, 1982.

Psychiatrists trained in a medical model (MM) approach, psychiatrists trained in a psychological model (PM) approach, and two groups of internal medicine specialists rated 20 psychiatric consultation services. The two groups of psychiatrists differed from each other on seven items. On six of these, PM psychiatrists also differed from both groups of internists. This group emphasized psychosocial factors more and psychiatric diagnosis less than either the internists or MM psychiatrists.

658. Randolph D.L. CMHC directors' preferences for training of bachelor's level psychologists. *Journal of Community Psychology* 7(3):228-235, 1979.

A questionnaire devised to measure preferences for training of bachelor's level psychologists was mailed to 302 community mental health center (CMHC) directors in the south-eastern United States; 117 or 39 percent completed and returned questionnaires. Based on the preferences of CMHC directors, bachelor's level candidates for employment in CMHC's should manifest the following: (1) a good foundation in generic core psychology theory; (2) training in fundamental intervention skills in the areas of group, family, and individual counseling/psychotherapy and consultation, plus crisis intervention and intake interviewing; (3) specialized training experiences in working with such high priority groups as disadvantaged blacks, the physically disabled, and alcohol/drug abusers; (4) knowledge of community resources and skill in public relations; and (5) personal characteristics that include personal warmth, a neat personal appearance, and good oral and written community communication skills. (abs.)

659. Rothenberg, M.B. Child psychiatry-pediatrics consultation-liaison services in the hospital setting: A review. *General Hospital Psychiatry* 1(4):281-286, 1979.

Two recent national surveys of consultation and liaison programs are presented; one survey was sent to departments of pediatrics, while the other covered divisions of child psychiatry. The development of a multidisciplinary, multi-departmental consultation and liaison group in a children's hospital is described and offered as a possible paradigm.

660. Schenkenberg, T.; Peterson, L.; Wood, D.; and DaBell, R. Psychological consultation/liaison in a medical and neurological setting: Physicians' appraisal. *Professional Psychology* 12(3):309-317, 1981.

Seventy-nine physicians who had been exposed to an independent psychological consultation/liaison service responded to a questionnaire dealing with the effectiveness of the program, possible limitations of psychologists working in medical settings, and the importance of psychological factors in medical disease. Their responses indicate strong support for the concept of psychological consultation/liaison

and strong endorsement of the importance of psychological factors in the etiology and treatment of medical disease.

661. Schmidt, J.J., and Osborne, W.L. Counseling and consulting: Separate processes or the same? *Personnel and Guidance Journal* 60(3):168-171, 1981.

Eighty-eight elementary school counselors were surveyed with the Myers-Briggs Type Indicator, the Fear of Negative Evaluation scales, and three other questionnaires on counseling practices and preferences. Pearson product moment correlations and multiple regression procedures revealed that when counselor activities were viewed in terms of global counseling and consulting processes, no strong correlates were identified with either how important the activities were considered or how frequently they were used.

662. Shonkoff, J.P.; Dworkin, P.H.; Leviton, A.; and Levine, M.D. Primary care approaches to developmental disabilities. *Pediatrics* 64(4):506-514, 1979.

Ninety-seven board certified pediatricians involved in the delivery of primary care in New England were interviewed to explore their attitudes and current clinical approaches to developmental disabilities. The majority were found to rely exclusively on clinical judgment and general observations for assessing developmental problems in their offices. Responsibility for preschool screening for potential learning problems were considered appropriate concerns. Reported customary approaches to a variety of developmental problems were not affected by the size of the practice nor by the socioeconomic status of the patient population. Patterns of referral for consultation appeared to be more dependent on the nature of the suspected disorder than on the characteristics of the physicians or their practices. The need for more precise techniques for pediatric development assessment and more conclusive evaluations of specific interventions is emphasized. (abs.)

663. Splete, H., and Bernstein, B. A survey of consultation training as a part of counselor education programs. *Personnel and Guidance Journal* 59(7):470-472, 1981.

Data from 144 counselor education departments indicate that since the training of consultation skills was prevalent,

the gap between professional encouragement for consultation and actual practice cannot be attributed to a lack of such training in graduate programs.

664. Tilley, D.H., and Silverman, J.J. A survey of consultation-liaison psychiatry program characteristics and functions. *General Hospital Psychiatry* 4(4):265-270, 1982.

A survey of medical-school-affiliated consultation liaison (C-L) psychiatry programs has provided useful information on several aspects of current C-L program activity, including patients seen and treatments provided; C-L training; program structure and fiscal operations; and subjective appraisal by program directors. Recording of better data and the development of more aggressive management techniques are proposed as appropriate foci of attention for C-L program leaders.

665. Timms, M.W.H. Survey of the needs for a clinical psychologist of Wicklow general practitioners. *Irish Medical Journal* 72(4):171-173, 1979.

Results of a questionnaire which was sent to all general practitioners in Wicklow, Ireland, to ask what services they would require of the clinical psychologist are presented. The questionnaire incorporated all the treatment and assessment facilities which the clinical psychologist had to offer as well as sections on teaching, research, joint consultation, and preferred mode of referral. Any doctor engaging in exclusively private practice was excluded. Of 55 questionnaires, 37 replies were received. Assessment of mental handicap was the most in demand, and services for children were also sought, with educational assessment for children the most popular demand. Some doctors added comments to the questionnaire indicating a recognition of the need for community education and of the value of the psychologist in the primary care setting generally. The five most requested treatment problems in order of importance were marital problems, phobic disorders, sexual problems, obesity, and addictive problems. There was a 100 percent request for teaching facilities. Findings are compared with those reported in a similar survey of Croydon general practitioners by Davidson (1977).

666. Tuma, J.M., and Schwartz, S. Survey of consultation training at the internship level. *Journal of Consulting and Clinical Psychology* 7(1):49-54, 1978.

Results of a survey of clinical psychology consultation internship programs are reported. A total of 111 American Psychological Association (APA) approved and 180 nonAPA approved clinical psychology internship programs were surveyed about consultation/liaison training. Fifty-four percent returned questionnaires, 84 percent of which indicated training offered in consultation/liaison psychology. The characteristics of these programs are discussed, and the programs offering consultation/liaison training are listed. (abs.)

667. Weinberg, R.B. Employment of master's-level psychologists. *Journal of Clinical Psychology* 35(3):687-688, 1979.

Results of a survey of employment of master's level psychologists in the States of Michigan, Indiana, Ohio, and Kentucky are presented and compared with two recently published studies. Results in all three studies are comparable: 87.6 percent of those mental health centers, State hospitals, and other mental health organizations surveyed report that they employ master's level psychologists. Duties of subdoctoral psychologists include testing therapy, and community consultation. The finding that future master's level psychologists may find greater employment potential in towns with a population of less than 50,000 justifies future research in the area of master's level employment to consider demographic variables. (abs.)

668. Wiggins, J.G. Psychotropics, consultation, and psychology. *Professional Psychology* 11(5):689-690, 1980.

A total of 30 psychologists from the Cleveland Academy of Consultant Psychologists were surveyed about patient contacts over a selected 1-week period, with particular reference to drug use--psychotropics, drug abuse, alcohol--and consultation. Results provided reports on 715 patients, of whom 180 (25 percent) were on psychotropic medication prior to consulting with the psychologist and 211 (29.5 percent) received psychotropics during the course of treatment, with psychologists participating in medication recommendations. Alcohol use was reported as high in 59, moderate in 158, and low in 152 (48 percent not reported on); 127 (18 percent) of the cases showed some evidence of

alcohol or drug abuse. Consultation with other health practitioners was sought in 285 (40 percent) of the cases. Results are discussed in terms of psychologist versus psychiatrist roles and responsibilities.

669. Wolstenholme, F., and Kolvin, I. Social workers in schools: The teachers' response. *British Journal of Guidance and Counselling* 8(1):44-56, 1980.

Results of a questionnaire survey of 73 teachers who had consultations about pupil management with school social workers indicate that 33 to 50 percent did not view consultation as very useful in providing practical techniques for coping with pupils. It is noted, however, that many teachers had only one detailed pupil-oriented discussion with a social worker.

See also:

54, 56, 64, 87, 116, 187, 230, 234, 264, 282, 297, 338, 357, 384, 472, 500, 504, 832.

Reviews

670. Alpert, J.L., and Yammer, M.D. Research in school consultation: A content analysis of selected journals. *Professional Psychology: Research and Practice* 14(5):604-612, 1983.

Analyzed are research articles published during the last 12 years on content and methodology utilized in consultation research. Attention was given to type of consultation, subject matter, setting for consultation research, research design, statistical techniques, and methodology. The analysis revealed that there does not seem to be continuity and follow-through in research on consultation. The literature represents discrete studies rather than systematic, programmatic research. Further, relatively unsophisticated statistical techniques were utilized. Survey questionnaires and baseline studies were also frequently utilized. Most of the research is behavioral, discusses individual cases, and focuses on remediation, and most concerns elementary schools.

671. Berlin, I.N. Resistance to mental health consultation directed at change in public institutions. *Community Mental Health Journal* 15(2):119-128, 1979.

An overview of the literature concerning the resistance to change in mental health consultants is presented. It is suggested that official agreement that change is necessary may still evoke resistance by those individuals most threatened. The consultant's awareness of how such resistance is manifested and used permits some educative counterefforts which may be effective. Case examples are given of effective and noneffective consultation. (abs.)

672. Cobb, D.E., and Medway, F.J. Determinants of effectiveness in parent consultation. *Journal of Community Psychology* 6(3):229-240, 1978.

Twenty-four studies that have empirically examined the process of parent consultation are reviewed to delineate those variables associated with positive therapeutic outcomes in parent consultation. Included in the studies are consultant, consultee, and client characteristics, and different consultation models and procedures. Despite increasing interest in parent education and training, research has yielded few definitive conclusions. Particular methodological problems inherent in this research are failure to control for the effects of particular consultants, to sufficiently describe experimental procedures to allow for cross-study comparisons, and to use immediate and delayed dependent measures which tap a range of parent and child behaviors. It is concluded that researchers should be urged to describe more fully the participants, procedures, techniques, and processes involved in their consultation projects. (abs.)

673. Johnson, R.P., and Geller, E.S. Community mental health and behavioral interventions. *JSAS/Catalog of Selected Documents in Psychology (APA)* 9:60-61, 1979.

Recent studies of programs within community health centers which apply behavioral principles are reviewed. Information was obtained from a computer search of *Psychological Abstracts* and supplemented by a cursory hand search of related journals. A request for information was sent to over 300 community health centers across the country, although relatively few responded and only 8 provided useful data. Results from that survey are presented and the data from those affirmative responses are

reviewed. Two large-scale attempts to establish behavioral community health centers are detailed. A variety of other studies of programs implemented within community mental health settings are highlighted and the results of the evaluations reported. Particular emphasis is placed on studies which focus on behavioral approaches to consultation, education, and staff evaluation. The practical and ethical issues involved in the implementation of behavioral community mental health programs are also examined. Suggestions are made for the use of empirical evaluation systems for both staff and clients within a behavioral framework, and the results of such efforts are discussed. Ideas for extending behavioral techniques into areas of the community concerned with improving the quality of family life are also described. It is concluded that behavioral techniques applied within community mental health center programs can be very cost effective when carefully designed and implemented. (abs.)

674. Kahnweiler, W.M. The school counselor as consultant: A historical review. *Personnel and Guidance Journal* 57(18):374-380, 1979.

This article contains a historical review of the school counselor in the role of consultant. Published articles that have appeared in four American Personnel and Guidance Association journals during the past 21 years provided the basis for the review. General trends in each journal and a developmental history of the consultation movement are presented. The conclusion was that a serious gap exists between the theory and practice of consultation in schools. Specific needs must be addressed for the school counselor as consultant model to be fully realized. (abs.)

675. Kaplan, R.E. The conspicuous absence of evidence that process consultation enhances task performance. *Journal of Applied Behavioral Science* 15(3):346-360, 1979.

The research literature concerning the effectiveness of process consultation in enhancing task performance of small groups is reviewed. The lack of any firm evidence for the facilitative effects of process consultation is cited, and the fact that most small group interventions appear to be isolated from task performance is lamented. Even where intervention studies measure performance, they usually fail to isolate the process intervention as the causal variable. The dialectic relationship between the humanistic values of

the small groups tradition and the effects of process consultation of task performance is discussed.

676. Mannino, F.V., and Shore, M.F. Addendum: Research in mental health consultation (Unpublished paper). NIMH, Bethesda, MD, 1978.

Research in mental health consultation since 1969 is critically reviewed, focusing on outcome research and studies which relate process and outcome variables. Increases in quantity, change areas studied, quality of the research, levels of change examined, comparison of conceptual modes, and studies relating process to outcome are treated. It is concluded that important advances have occurred over the last decade, and that there has been significant clarification of conceptual definitions, greater methodological sophistication, more attention to outcome criteria, more comparison with different modes and practices, and new attempts to relate process variables to outcome. The need for continuing emphasis on this complex field of research is discussed, along with specific recommendations for further studies.

677. Mannino, F.V. Empirical perspectives in mental health consultation. *Journal of Prevention* 1(3):147-155, 1981.

The evolution of mental health consultation over the past 10 to 15 years is traced, and two areas of empirical research in the field are discussed. Although mental health consultation has evolved into one of the most significant forms of intervention and prevention in the area of community mental health, its growth has not been one of smooth and steady progress. During periods of austerity, it is still the easiest service to trim with the least risk of incurring community resistance. This vulnerability makes it increasingly necessary to use whatever means are available to affirm its credibility as a viable practice method. One such means is the use of research and evaluation to gain greater knowledge and understanding of consultation as a helping process, and through the application of knowledge gained to continuously upgrade and improve consultative practice. Research-focused studies are concerned with knowledge building and can provide a base for legitimizing mental health consultation. Practical, program-focused research can assist in the planning and quality assessment of a particular consultative program or service. (abs.)

678. McKegney, F.P., and Beckhardt, R.M. Evaluative research in consultation-liaison psychiatry. Review of the literature: 1970-1981. *General Hospital Psychiatry* 4(3):197-218, 1982.

In the last decade, the biopsychosocial concept of medicine had flourished clinically in the form of consultation-liaison (C-L) psychiatry. This review surveys the literature over the last 10 years that describes and evaluates C-L activities as they affect clinical medicine and medical education. A conceptual grid for organizing research in the field is presented that distinguishes decision-oriented or descriptive studies from conclusion-oriented or outcome studies. Further, this grid specified the focus of the C-L activity, either the patient or health care professional. It seems clear that the very recent shift from descriptive studies to outcome-oriented research particularly regarding patient outcomes, should be the direction of the future. A greater emphasis on defining the exact components of C-L work that are most useful is also indicated. Several other specific recommendations for evaluative research in C-L psychiatry conclude this review.

679. Medway, F.J. How effective is school consultation?: A review of recent research. *Journal of School Psychology* 17(3):275-282, 1979.

Examines findings of 29 studies of school consultation published between 1972 and 1977. Twenty-two studies reported at least one or more positive effects resulting from consultation interventions. Behavioral consultation was found to be particularly effective. Several methodological limitations that reduce the generality of the findings are discussed. These include lack of appropriate experimental control procedures, failure to control for individual consultant and consultee characteristics, and infrequent use of multiple dependent measures assessing both attitudinal and behavioral changes. Despite the problems entailed in measuring consultation outcomes, the practice does appear to be effective. Suggestions for further research are presented.

680. Medway, F.J. School consultation research: Past trends and future directions. *Professional Psychology* 13(3):422-430, 1982.

Reviews and evaluates school consultation research conducted during the past decade. Attention is given to the breadth and quality of the present consultation knowledge base, the appropriateness of data analysis procedures, and

the impact of consultation research findings on consultation training.

See also:

9, 342, 540, 838.

Technical Innovations

681. Glazer, E.; Marshall, C.; and Cunningham, N. Remote pediatric consultation in the inner city: Television or telephone? *American Journal of Public Health* 68(11):1133-1135, 1978.

The use of television and telephone for innercity pediatric consultations by nurse practitioners was compared. An East Harlem preschool primary care clinic staffed by four pediatric nurse practitioners using written protocols was the study setting. Telephones or televisions were used to connect the clinic examination rooms to the pediatrician's hospital office. For diagnostic consultations, the nurses preferred the television, while for therapeutic consultations, the telephone was preferred. It is suggested that the telephone was preferred for its convenience in the instance of therapeutic consultation and that a more mobile television unit would be preferred if available.

682. Heiser, J.F.; Brooks, R.E.; and Ballard, J.P. A computerized psychopharmacology advisor. Continuing medical education: Syllabus and proceedings in summary form. Washington, D.C.: American Psychiatric Association 1978.

A summary of a paper read at the 131st Annual Meeting of the American Psychiatric Association, held in Atlanta, May 1978, is presented. The existent, developing, and potential applications of computerized systems for education and consultation in clinical psychiatry are discussed. A computerized psychopharmacology advisor is described which is capable of evaluating and diagnosing psychiatric patients, suggesting pharmacological treatment, monitoring a patient's clinical course, and indicating changes in treatment. Completely interactive, this system explains its reasoning in terms that are accessible to users of varying sophistication, can have its behavior completely analyzed, and is easily modified and updated. (abs.)

683. Taintor, Z.; Spikes, J.; Gise, L.H.; and Strain, J.J. Recording psychiatric consultations: A preliminary report. *General Hospital Psychiatry* 1(2):139-149, 1979.

Two new report forms specifically designed for computer processing of data from a contemporary consultation/liaison service are described. The need for such data and the immediate applicability of the forms to problems currently facing this psychiatric subspecialty are discussed. Clinical, administrative, and evaluation uses are reviewed. Consultation/liaison psychiatrists are urged to use this system or to develop similar systems that will permit documentation, exploration, and enhancement of the consultation/liaison effort. (abs.)

2. DISSERTATIONS AND BOOKS ON MENTAL HEALTH CONSULTATION

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